The perception of video-recorded consultations as an educational tool in aiding self-reflection in a general practice setting

By

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A Thesis submitted for Master's Degree in Medical Education

July 2018

Acknowledgements

My most sincere appreciation goes to God, who has been my source of strength and courage always.

I am most grateful to my husband, 'Tosin and our three lovely kids ('Temisire, 'Temisayo and 'Temisola) who have been very supportive and understanding throughout. Your frequent hugs and kisses will never be forgotten.

I also want to appreciate the immense contribution of my in-laws, parents, siblings, friends and colleagues who have offered their words of encouragement and advice. Your kind input is greatly appreciated.

And to Claire, you are one wonderful tutor. Thanks for being there for me.

Supervisor

Claire-Marie Lindsell

Lead Tutor for the RCP-UCL MSc in Medical Education

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ABSTRACT

Background

General Practitioners (GPs) are the first point of contact for patients seeking medical care. The level of communication between patients and their GPs needs to be of a high quality to yield a satisfactory patient-doctor relationship and a successful clinical outcome. Self-reflection is generally considered a significant element in this process for doctors in general practice. GPs are encouraged to utilise a variety of strategies to aid self-reflection as a means of identifying learning needs and improving their overall clinical practice. One such strategy is the use of video to record clinical consultations which can be subsequently watched and utilised to facilitate a purposeful reflective process. The incorporation of video recordings into clinical practice is highly recommended by the Royal College of General Practitioners (RCGP) and it is important to explore GPs' perception of their use as an educational tool and its impact on self-reflection. This study looks at the perception of video-recorded consultations as an aid to self-reflection in a general practice setting. It has been conducted among general practice registrars who are in their final year of training and who regularly use video for feedback and reflection.

Methods

A descriptive cross-sectional qualitative study method has been used which employed a purposeful sampling method among all 30 general practice registrars within a Southern general practice community who regularly use videos. Ten GP registrars offered to take part in the study. Data collection methods, guided by an

inductive research approach aimed at generating new and diverse opinions without a pre-existing hypothesis, included one focus group session comprising six participants and four semi-structured individual interviews carried out face to face and by telephone. Data obtained was audio-recorded digitally and transcribed. It was analysed thematically informed by the grounded theory to yield themes that aimed to answer the research question.

Results

All the participating GP registrars found the process of self-reflection very useful for learning and identifying areas for improvement. They also considered it as a means to identify their knowledge level, knowledge gaps and ways to further improve communication skills. As well as aiming to improve self-development in general, self-reflection was also recognised as a potential fault-finding process, which could lower self-confidence in certain situations. The use of video was rated as a powerful educational tool as it is an objective method of observing one's own consultation that can be re-watched in the future. It was recognised as offering the potential to improve communication skills in GP consultations. However, the challenges were unanimously highlighted as the registrars reported that they found video-recorded consultations very unnatural and awkward to watch. They also suggested that video-recording within an allocated time causes increased performance anxiety. For these reasons, there were heterogeneous views of the use of video in aiding self-reflection. Some mentioned that video-recorded consultations can be useful as an aid to self-reflection due to its objectivity; however, others did not consider these to be helpful for reflection as other strategies may be equally employed to yield similar outcomes.

Discussion

These results may indicate the general view that reflection is crucial for self-development and that it also offers autonomous learning opportunities. In this case, self-reflection among GPs is deemed essential to identify what went well in a consultation, as well as unexpected outcomes, knowledge gaps, learning needs, useful non-verbal communication styles and areas for improvement. In that context, trainees believed that the use of video as an aid towards the reflective process can offer objectivity, an opportunity for feedback and added insight into their consultation. These can then be utilised to promote change in consultation style and improved clinical practice, with better patient satisfaction and outcome. The disadvantages of video-recording of consultations as an aid to reflection, especially in the time-pressured environment of general practice, makes its perception quite disparate. The discomfort felt in watching oneself, coupled with the challenges of set-up and patient consent, including the unnatural environment of consultation, do not encourage the regular and frequent use of videos for reflection.

CHAPTER 1: INTRODUCTION

This section gives a **background** to the topic and includes a **literature review** including the methodology used. It also offers a discussion and critique of the literature and how this applies to the topic being researched.

It explains the rationale behind the research questions and sub-questions and discussed the relevance of this research topic to the author.

1.1 Background

In a GP setting, patients need to be seen within a limited time-frame and a meaningful clinical outcome is expected after such consultations. The pressure on the GP to ask the right questions, make a diagnosis, establish a management plan and ultimately be understanding and empathetic within this allocated time is immense. Sometimes consultations go very well and both the GP and the patient are happy with the outcome. At other times, the process doesn't develop quite as planned or expected between both parties. This could be due to a variety of reasons, including a breakdown in communication or the unmet needs and expectations of the patient. Whether each patient encounter is a positive or negative experience, GPs have a duty to self-reflect on their consultations and to consider their attitudes, clinical knowledge, ability to negotiate and deal with uncertainties. This self-reflective process is not novel and various disciplines covering all professions and walks of life have incorporated the practice into their working methods in past decades.

Self-reflection can be a very meaningful process if done appropriately. It can act as a mirror enabling an individual to look inwards to better examine their conscience, behaviour, attitude and emotions – possibly associated with a specific event. These attributes strongly echo what is expected of GPs. The ability to self-reflect varies between individuals and may be dependent on experience, personalities, the current state of one's mind or one's capacity to critically analyse a consultation. For some people, this may come naturally and for others it may require the acquisition of certain skills and aids.

A key aid in achieving satisfactory reflection may be found in the use of videos. Several disciplines have engaged with videos for diverse reasons, including for simulation, teaching and feedback, and much evidence has been gathered regarding their benefits as a useful educational tool as well as some drawbacks. These studies include work done by Dowrick, 1999; Farquharson et al., 2013 in addition to Fukkink, Trienekens, and Kramer, 2011. Other studies were by Nilsen and Baerheim, 2005; Lindon-Morris and Laidlaw, 2014. There has been increased interest in recent years, for example, studies by Andrist et al. (2014) and Mayer & Gallini (1990) were carried out to better understand the pedagogy that underpins its use. Koumi (2014) & Woolfitt (2015) have also contributed to the knowledge that demonstrates the effective use of video in higher education. This may account therefore, for the reason why videos continue to remain a helpful tool in the field of education. Video recording allows the capture of a "pure event", free from assumptions. They may also be watched at a later time which makes it possible to apply to a setting within general practice.

Consequently, it may be useful to think that videoing a consultation to view later may aid a GP's ability to deeply self-reflect on their approach to their patients and their attitudes that otherwise may have gone unnoticed. This may help the doctor decide what did or did not go well and what can be done differently to achieve a better consultation.

A scrutiny into how GPs self-reflect, what prompts them to self-reflect and how videos may be an aid in improving the quality of their self-reflection has sparked the author's interest in evaluating this subject area. As a GP with an interest in medical education, it is my intention to explore the pedagogy and the educational learning theory that underpins the concept of self-reflection and the use of videos in aiding self-reflection. It is hoped that findings from this evaluation study may generate new ideas and assist GPs in developing a learning process that will produce a happy doctor and a happy patient. Being the first point of contact for the general population, the importance of this in a GP setting cannot be overemphasized.

1.2: Literature Review:

1.2.1 Literature review methodology:

An organised literature search was conducted by using a standard search guideline (PICOS approach) as defined by the Great Britain Centre for Review and Dissemination (2009). The PICOS approach has allowed the research question to be simplified to Population, Intervention, Comparator, Outcome and Study Design. In this case, these are categorised as follows: Population (GPs), Intervention (Video-recording), Outcome (Self-reflection) and Study Design (considering any study method). The comparator was not considered a valid component of the search as it is deemed more appropriate for use in quantitative research methodology and has therefore not been adapted for this qualitative research project.

Resources were obtained from electronic journal databases including Open Athens, UCL online library, Wiley and PubMed. Google and Internet explorer were used to search for the keywords that underpin the research question. In addition, references from similar studies, library catalogue and online professional materials were explored in detail to widen the depth of the search results. The search was generated by using the research question and using synonyms and abbreviations that represent the components of the research question. The inclusion criterion here was that all searched articles must be relevant to the topic, irrespective of the date when the article was written, the geography or design study. The search also included the use of video consultations in other disciplines other than General Practice. Journals or articles not written in English were excluded.

This literature review has been organised as follows: the first section explores the pedagogy and significance of self-reflection in a work environment. The second section reviews video consultations as an educational tool, the learning theory that underpins it use and its application in a general practice setting. The final section highlights articles that discuss the impact video recording of consultations have on self-reflection. This section will also cover the learning theory that applies to this principle, especially among GPs.

1.3 The significance of self-reflection in a GP setting

Reflection is a major component of everyday living, whether it is done actively or sub-consciously. Sometimes it occurs as a result of an academic exercise based on theoretical thinking, and at other times it may be very spontaneous borne out of a specific experience. Irrespective of the method of occurrence, it does appear that self-reflection has become ingrained into our daily experiences. The pedagogy underpinning the various cycles of reflection has been explored by educators from time immemorial. One example is the noble work accomplished by Schon (1983) which has been referred to by numerous researchers to support the critical analysis of reflective practice.

Schon (1983) explains that an individual learns by reflecting *in-action* and subsequently, reflecting *on-action*. This originates from a Constructivist approach where an individual has the responsibility for his or her own learning through reflection. Reflection *in-action* in gen for example, enables a doctor to think on the spot when seeing a patient and generate new ideas for moving a consultation

forward. In the process, he or she may be able to interpret what a patient really needs and offer a clear and shared management plan. Reflection *on-action* however, is a thorough look at how a consultation happened once the patient has left. This could be immediately after or after some time has passed. The benefit of this is that the doctor reflecting can make changes for the future as a result.

1.3.1 Self-reflection in a work environment

In a work environment, especially within general practice, this process has seemingly moved from merely recalling past events or actions in order to identify mistakes, to critically reviewing or "*exploring thoughts and feelings, looking for insights and maximising self-awareness*" Lacan, (1977 cited in Helyer, 2015, p.15). Schon (1983) has further identified that an employee who is keen to engage in reflective practice has a lot to offer in their job role and has a high chance of improving their future career prospects. In the changing world of employment, workers need to be able to offer expertise, specific skills and outstanding personal values to thrive in their careers and to also remain employable and dynamic in whichever form this may be required. Helyer and Lee (2012, cited in Helyer, 2015, p. 16) further asserted that "*it is the receptive and self-aware job seeker who will find the most success in what is currently a highly competitive and congested global market*".

1.3.2 Improvement in self-awareness and self-development

Similarly, in a GP setting, there appears to be an undeniable relationship between self-reflection and how GPs consult in order to develop management plans for their patients. Self-awareness and self-development are intrinsic to the manner in which

care is delivered to the patients. A GP who is aware of their clinical strength may choose to manage a patient in primary care while one who is not quite so confident may choose to refer a patient on for more specialist care. This ability to become aware of one's strengths and weaknesses, areas for development and learning is a product of critical reflection. Whilst Billet (2010) in his research submits that the strong relationship between self and work has an immense influence on how an individual recognises or identifies themselves, Brockbank & McGill (1998) and Maudsley & Strivens (2000) inferred that a significant part of that relationship rests heavily on the strength of an individual's reflective skills and his or her innate ability to take ownership of their learning and development. Invariably, therefore, this means that a doctor who wants to thrive in the ever-evolving world of general practice should be reflective (whether *in or on action*) in order to be able to perform well in their clinical role and chosen career.

The position Schon (1983) has assumed in the work on reflective practice has been referenced numerous times as it seeks to explain the epistemology and pedagogy behind the link that connects an individual, their ability to reflect and their experiences in practice. However, it is understandably plagued by criticisms by Greenwood (1993) who posited that Schon has not given importance to "reflection before action". It has been iterated in this piece that reflection starts before the *in-action* phase, which will then be followed by the *on-action* phase naturally. Another researcher has joined Greenwood (1993) in questioning Schon's philosophy of reflection *in action*. Moon (1999) argues that it can be hard for individuals to detach themselves away from an activity while it is occurring. This notion has been asserted

by Van Manen (1995, p.2) who posited that '*learning from true reflection largely takes place when there is the opportunity to step away from an event so as to appraise it retrospectively*'.

The point here therefore is that reflective practice as described by Schon (1983) appears to be more exhaustive in illustrating how a GP may reflect about his or her patient-doctor dialogue. A GP may reflect during the consultation, reflects afterwards (according to Van Manen, 1995) and reflects before repeating a similar or different experience in the future as supported by Greenwood (1993). To support all three authors (Greenwood 1993, Schon 1983 and Van Manen 1990), it will seem that reflecting later, by stepping away and watching a video of the 'pure event' will trigger critical analysis. It may be challenging to completely recall events, especially the '*in-action'* phase. Hence, video may become useful in exploring this aspect. The use of video-recording therefore seems logical as a perfect aid to capture events, especially in consultations, so that doctors can watch and retrospectively reflect on their attitudes, behaviour, approach and communication. The next section here, explores the educational value of videos and their usage in general practice.

1.4 The educational value of video-recording in general practice

Video-recording has many purposes which include usage in teaching, giving feedback and in reflection on how certain tasks have been performed or skills demonstrated. This can be seen in the field of simulation where doctors engage in artificial role play to demonstrate competence and after watching themselves can subsequently reflect

on their actions and communication skills. On a similar note, it is worth considering the educational benefits of video-recordings of consultations in GP.

1.4.1 Value of videoed consultations for teaching communication skills

One cannot comment on the value of videos in general practice without due reference to the work done by Miller (1990) in describing the Miller's pyramid of competence. This pyramid demonstrates aspects of knowledge (knows) at the bottom, which moves up to competence (knows how), then performance (shows how) and which tapers at the highest tip of the pyramid to action (does). Assessments by the RCGP naturally follow this pyramid to ensure that the doctors they train are equipped to function at the required high levels. GPs are expected to perform at the pinnacle of the pyramid and are therefore expected to demonstrate their clinical ability by "doing".

'Doing' in this case refers to the ability of a doctor to engage and dialogue with a patient effectively in order that a shared decision is made. A decision that is clinically sound as well as one in which the patient is aware of what is going on and the reasons why specific clinical decisions have been made. This is ideal communication in GP and this is often demonstrated using videos and reflective log entries on an electronic portfolio (e-portfolio). The ideology of video-teaching and video-reflection has been significantly imbibed by the GP community, where both doctors in training and fully qualified GPs are continually encouraged to video their 10-minute consultations. This allows them to view communications with their patients and thereby reflect and learn which can then lead to a change in their practice.

According to Inui & Carter (1985 cited in Coleman, 2000, p.422) '*Of all observing and recording techniques, video-recording has been recommended as the best method for researching doctor–patient communication because it captures all modalities of the interaction between participants in a consultation*''. Some studies have shown evidence of this assertion. For example, Arborelius & Timpka (1990) explored the interaction between GPs and their patients and Arborelius et al. (1992) conducted a study to offer insight (through the use of video-taped GP consultation) into what makes a good or bad GP. Both observed filmed consultations between several GPs and patients to gain an understanding of this dynamic and complex relationship between a patient and his or her doctor.

Following on from this, it does appear that the video-taping of consultations has a crucial role in diverse areas, from the acquisition and enhancement of knowledge as identified by Garcia-Rodriguez & Donnon (2016) to learning of communication skills as iterated by Eeckhout et al. (2016). Eeckhout et al. (2016) emphasised that filmed consultations open learning avenues for GPs. They were deemed useful for obtaining visual feedback which was deemed superior to feedback given by someone else. Not only that, filmed consultations were identified as an essential method of checking whether an attitude was appropriate during a consultation.

Apart from the study carried out by Eeckhout et al. (2016), there appears to be very little in the field of research and enquiry into the use of videoed consultations in general practice. Even though Arborelius & Timpka (1990) and Arborelius et al.

(1992) utilised video in exploring the patient-doctor relationship, there was little emphasis on the power of video and its other benefits within a GP setting. This would have fallen out of the scope of their research. An exhaustive literature review for existing studies to explore the relevance of video teaching/recording or feedback in a GP setting is sadly limited.

The advantages of video-teaching also span from its usefulness in illustrating clinical conditions to capturing clinical signs in patients in real-time. It also serves as an aid in assessing affective skills and professional behaviour. These skills are often challenging to explain or demonstrate. A good comparison of good and bad affective skills can be clearly demonstrated using video-consultations. These support audio-visual learners and most importantly, can offer flexible teaching and reflection opportunities where the video can be paused and even watched again in a doctor's own time and space. Video-recording lends itself to the opportunity for feedback from a critical friend, enabling consultations to be watched by others who can give feedback. This can also be a tool in aiding self-reflection.

1.5 The impact of videoed consultations on self-reflection within general practice

The theories that underpin the use of videos as an aid to reflection can be explained using the experiential learning cycle as explained by Kolb (1984) and Schon's reflection *in-action and on-action* (Schon 1983). The latter has been discussed in the earlier section of this literature review. The former is a four-stage cycle of learning and learning styles, hinging on internal thinking processes and deep reflection. It

explains that an experience such as reviewing a patient in the consultation room is followed by a review, reflection and a development of high cognitive function that induces learning. This is the point at which self-reflection takes place, enabling ideas to be engendered that will inform changes in clinical practice. It is at the level of "reflective observation" that videoed consultations may allow an objective assessment of knowledge, attitudes, professional behaviour and communication skills. These attributes are visible to the doctor and may aid self-reflection rather than a subjective self-assessment or a narrative from an observer.

An in-depth look into how videos may be used to facilitate high cognition and reflection was carried out by Hollingsworth & Clarke (2017), Hunukumbure, Smith & Das (2017) and Stockero (2008). These studies showed how their participants have put this concept in practice. Stockero's work showed that teachers were able to promote reflection not by merely describing events (identified as low level of reflection), but by hinging their reflections on some form of evidence or theory (high level of reflection) within their practice. This could bring about opportunity that could engineer change to more suitable and acceptable forms of teaching practice.

The study by Stockero (2008) especially stands out as it resonates with what may be encountered in general practice. This study explained that their pre-service teachers were able to intently look at the substance of communication in teaching. This substance encompasses the relationship between teachers and students, the thought processes of the teachers and the students rather than just the communication style. Interestingly, one could say that this is exactly what general

practice is about. For the GP, the beauty of an excellent consultation is not only in the communication style, but a good understanding of the patient's ideas, health concerns and expectations. A good insight into these can only be developed if such GP commits to critical reflection of their own thinking processes as well as their patient's. During a consultation, there are non-verbal messages that a patient may pass on to their doctor subconsciously or in fact, messages given verbally that may go completely unheard. This may not be due to the doctor's poor listening skills or inability to pay attention but may be due to the mental work that is needed to understand the problem at hand and proffer solutions to solve the clinical dilemma. Therefore, one may ask – is there a better way to capture all these in real-time other than a video-recording?

According to Hollingsworth and Clarke (2017) and Hunukumbure, Smith & Das (2017), self-reflection emanating from watching a video of an event helped the participants to recognise some attributes in communication and technical skills that may not have been previously noticed. Therefore, offering an opportunity for a change to a preferable communication style that induces better outcome. Hunukumbure, Smith & Das (2017) further noted that among the benefits of video in fostering self-reflection, is its power to portray videoed events in reality. This can be utilised for evidence-based reflection better than what memory can offer. In their inductive research, although both studies sought to explain the positive significance of video and feedback under teacher supervision, the relationship between video and its possible negative impact on self-reflection on their students was especially

highlighted. One of these challenges was that of the teachers' reservation for filming their teaching sessions due to dislike for watching themselves.

The above research studies have been corroborated by Ajayi (2015) who conducted a study with similar methodology based on an inductive research background. Here, it was concluded that video has a role in the identification of critical events that can drive critical reflection. Beyond that, Ajayi (2015) also identified that videos are more useful assistants in recollecting events of the past than memory. In these three studies, the benefits of using filmed events for self-reflection were thoroughly emphasized. Even though their research questions were geared differently, they appeared to have reached similar conclusions.

Similarities also appear in the methodology adopted for the above two studies by Ajayi (2015) and Hunukumbure, Smith & Das (2017) as they were based on similar research approach. Despite this, the strength of their studies varied immensely. Whilst the latter were able to identify and discuss the challenges of video recordings in reflection, in addition to the benefits, Ajayi (2015) did not present or discuss challenges of video recordings in their research work.

From the above studies, it is evident that video use in general practice fosters real-time access to consultations that have occurred in the past and which can be watched and used for reflection later. These studies have shown that there is the potential that videos can help doctors to identify errors in communication and learning needs and thus foster professional development. Furthermore, they can

allow for the identification of critical events within a consultation which can be a stimulant for reflection.

Nevertheless, the researchers reported that a challenge was persistently encountered in their studies, although they were carried out in different contexts. One of these challenges is that videos have the potential to provoke anxiety and may give rise to the perception that the consultation is not a natural occurrence. They found that recording of videos for any event, whether in teaching or within a clinical practice, is subject to "performance anxiety" - although most reported that participants generally got used to the idea over time. However, can one say the same for general practice where patients are not predictable, and the presence of a video might equally exacerbate the already present health anxieties further escalating the performance anxiety for the doctor? Despite these challenges, it is worth exploring how the video-recording of consultations play a role in self-reflection among the general practice community. It is the aim in this research study that this question can be explored among the participants to obtain their perception. This may generate answers that support previous findings as explained. On the other hand, it may open further questions for discussion in this research work.

The studies mentioned above have similarities in their methodologies. They were descriptive and interpretive in their approach and bear some resemblance to the research question being asked here. Although the methodology that may be used in this qualitative study may be similar, it has been adjusted (with consideration for

their strengths and weaknesses) to ensure that it is the appropriate methodology to answer the research questions in this context.

1.6 Research Question

It has become imperative to conduct research among doctors in general practice to examine the relevance of video-consultation and its impact on self-reflection. The research question is therefore stated as follows:

What is the perceived value of video-recorded consultation as an educational tool in aiding self-reflection in a General Practice setting?

To fully explore the breadth of this research question, sub-questions are required to further dissect it into an easily answerable format that will inductively generate meaningful themes. The sub-questions are therefore:

1) What is the significance of self-reflection in General Practice?
2) What is the perception of video consultation as an educational tool in a general practice setting?
3) How can video consultations help in fostering an opportunity for good self-reflection?
4) What is the difference in the quality of self-reflection with and without the use of videos?

CHAPTER 2: METHODS

This section describes the participants involved in this study and their setting including data collection methods and methods of data analysis.

It also explains the methodology that underpins this research work

Ethical considerations, researcher's bias and the study schedule have also been included in this section.

2.1 Setting/ Participants

The setting of this research is based within the general practice community. In this case, it was conducted among the 30 Southern general practice registrars who regularly video their consultations to obtain feedback and self-reflect on their clinical practice. Similarly, all GPs, irrespective of their stage of training or hierarchy, are expected to reflect on their daily consultations and make deductions on how their next consultation can be better than the last and what can be done to make those changes. As part of general practice training, video-taped consultations are an easy way for trainees to observe themselves to test, review and reflect on their communication abilities, a required skill for passing the Royal College clinical skills examination. Video-taped consultations happen nearly every day and therefore have become very popular among this group of specialty trainees. The educational role of the author of this study, therefore, is to explore the perceived views of video-recorded consultations as an educational tool to aid self-reflection among the GP registrars.

2.2 Study Design

This is a descriptive cross-sectional qualitative study. The research study decisions have been guided by an approach by Saunders et al. (2007) who described the steps in research design as a series of onion rings in which the outer layer is the research philosophy, down to the core that guides data collection methods and analysis. Interpretivism as explained by Bryman & Bell (2011) clearly describes the philosophy that will underpin this research, providing the opportunity to seek to understand

how people may differ in their opinion of issues or perception of ideas. However, the interpretivists' ontology contrasts with the positivist point of view which advocates that there is only one truth and one reality, and that data should be obtained to explain the known truth. The ideology of positivism elaborates the weaknesses of interpretivism in that there is a significant risk that the researcher's personal values and ideas may constitute bias, thus reducing the study's validity.

Despite the contrast between both epistemologies, within the scope of this research there is an inclination towards interpretivism, which allows the research question to be answered in detail by the GPs involved in this study. The Interpretivist approach as explained by Bryman (2012) does not allow for the presumption that what is perceived by one single GP should automatically be perceived by the others. There needs to be variability as individuals perceive differently and this reality should be recognised and explored. Many researchers may argue that their work cannot be fully devoid of epistemological assumptions and these do not automatically limit the validity of their study. Therefore, the essential approach here is to test the data to detect the similarities and the distinction of perception between participants.

In examining the differences in perception among these GPs, the aim of this research is to generate meanings from the data collected as supported by Bryman & Bell (2011). This means that the basis of this methodology is the grounded theory proposed by Glaser & Strauss (1967) which identifies with an inductive research approach. It is appropriate here as it allows recognition of patterns to produce

conclusions from thematic analysis of data Beiske (2007). It may mean that new theories are generated, or the data may yield findings that fit into an already existing theory. This contrasts with the deductive approach (linked to Positivism) where there is an existing hypothesis based on a pre-existing theory where the research lends itself to obtaining data to test this hypothesis (Silverman, 2013). This does not align with the scope or context of this research.

2.3 Sampling method

The sampling method employed was purposeful. All 30 GP registrars were invited to take part in the study via their weekly mandatory teaching session within the education centre, thus enabling all 30 to be approached at the same time. Targeting all of them at the same time presented the opportunity to recruit enough participants to ensure adequate response. Interested participants were offered the opportunity to read the information sheet and sign the consent form.

2.4 Data collection methods

The examples of data collection methods that consolidate the research study philosophy and approach as explained by Saunders et al. (2007) include focus groups, interviews and observations. In line with the research philosophy and approach explained within the context of this study, it appears logical that focus groups or interviews will be the ideal research strategies needed to obtain the required data – focus groups being the preferred choice.

Focus groups offer interaction (Kitzinger, 1995) and organised discussion (Kitzinger, 1994) as a collective activity (Powell et al., 1996). They enable the generation of multiple insights and responses from the registrars. The beliefs, attitudes and personal experiences explored in such groups offer an opportunity to capture data from multiple sources simultaneously. They provide a relatively quick way of generating data from a relatively large percentage of the trainees that may reflect a good proportion of the overall number of the total participants. Conducting focus groups helps to develop questions or concepts for probable future questionnaires or interviews (Hoppe et al., 1995) & Lankshear, 1993). Furthermore, they offer the flexibility to delve deeper into issues that come up during the discussion with a variety of people at the same time. This is often not possible with other research methods.

Alternative research strategies include the use of questionnaires, semi-structured interviews or observation, although these methods do not yield a large amount of information in a short period of time. They aim to obtain individual views and perception and are time-intensive for all participants. They may also generate excessive data for the scope of this research study. However, they may be used to establish triangulation of data to strengthen the validity of the study in the event of inadequate responses from focus groups.

2.5 Data analysis

Data was thematically analysed - a widely used qualitative analytical method that offers flexibility which can be used to identify and report patterns that have been generated from a data set (Holloway & Todres, 2003). Such analysis enables emerging themes to be identified which capture important details in relation to the specific research question. This means that the recognised themes are firmly connected to the data (Patton, 1990) and falls clearly in line with the inductive research approach defined earlier in this proposal. An inductive or "bottom up" approach as explained by Braun & Clarke (2006) is clearly data driven and does not allow data which is generated or coded to fit into a pre-existing frame or the author's analytic preconceptions. Although, in this study, a mixed methods approach was eventually utilised as there were some pre-existing codes that helped to guide the questions for data collection. However, this does not underplay the significance of adhering to an inductive research within this study.

2.6 Actual methods adopted

Of the 30 Registrars, 12 expressed interest in attending the focus group session. Their names and contact details were obtained, and reminders sent out to them beforehand. The original plan for data collection was to carry out two separate focus group sessions, each comprising at least six participants. However, only six registrars attended and the others sent their apologies. The focus group discussion was scheduled after the mandatory teaching session for the registrars. The room had been prepared beforehand with a microphone connected to encrypted software

used by the education centre for audio-recordings and hospital-based research. This was personalised to the author who had sole access and maintained anonymity and who destroyed the data later.

Discussions generated from the focus groups were also captured using the Dictaphone and stored on an encrypted USB stick as a backup. The author facilitated the hour-long focus group session, with the assistance of question guides. The questions in the guide were informed by the research questions and sub-questions. Since there were four main questions, it seemed logical to develop them structurally into themes/questions that would trigger discussion. These questions can be reviewed in Appendix A.

As there were fewer doctors than anticipated, a further focus group session was not scheduled. This had been planned to explore any further questions that were not adequately covered in the first session, or to buffer or consolidate the findings emerging. The decision not to coordinate another session was taken to allow for a more individualised data collection method. As discussed earlier in the literature review of the research methodology, it would seem appropriate to use semi-structured interviews to acquire further in-depth data that can be used for triangulation.

The doctors who could not attend the focus group sessions were subsequently contacted and semi-structured interviews of 60 minutes were carried out. A question guide was also developed for these interviews (Appendix B) which allowed for a thorough enquiry of ideas already emanating from the focus group discussion. Data from the interviews, which were conducted in various locations, was captured using encrypted Dictaphone.

Data obtained from both the focus group session and the four semi-structured interviews were transcribed independently by the author. Data analysis was carried out by thematic analysis - the most widely used data analysis method in qualitative research as mentioned by Braun and Clarke (2006). To ensure that any qualitative research is trustworthy, it is very crucial for researchers to execute data analysis in the most thorough and reliable manner. Therefore, to ensure the credibility of the data analysis undertaken in this project, a meticulous and systematic approach was incorporated which consisted of a first thorough reading of all transcribed data to understand responses, how they might be relevant in answering the research question, and to familiarize the researcher with the data.

A further reading later took place to identify and place initial codes on the data, at the same time highlighting quotes that will be used to justify answers that answer the research question appropriately. The third step was the search for possible themes which were subsequently reviewed and mapped. Ultimately, the data was analysed by defining themes which may generate new theories or develop theories

that may already be in existence in order that the research question is appropriately answered and applied within the GP setting. Responses from the focus group were analysed independently from those of the semi-structured interviews. Likewise, the themes were generated separately. The over-arching themes from both parts of the data collection were then combined as merged overarching themes. This can be reviewed in the Appendix section.

The themes were initially divided into different sections based on the research questions and sub-questions on self-reflection, videoed consultations and lastly, the impact of videoed consultations on self-reflection and its quality within a GP setting. The first section generated individual sub-themes that explained the perception of the trainees. Following this, the sub-themes were further collapsed into bigger ones that offered a more comprehensive but succinct meaning without losing any originality. The second section was however explained under two main broad themes as expressed as positive and negative effects of video-recorded consultations in GP. This was found to be too expansive to explore the full concept of what was being expressed by the participants. It was found that the unique individual perceptions of the different trainees were lost in these two themes. This goes against the grounded theory and inductive research approach that guides this research work. Therefore, the data was recoded, re-themed and re-analysed to reflect the true responses and perception. The thematic analysis of data for the last section was carried out in a similar manner to the first section. Huge themes that swallowed up the original meaning and personal individual responses were avoided.

2.7 Researcher bias

Researcher bias can be identified here as the author at the time of executing the data collection was a GP registrar and the use of a purposeful sampling method proved to be very convenient. Although it was assumed that due to the bias the study participants would be easily recruited, it turned out to be more challenging due to time constraints and individuals' plans. Also, as the study participants belonged to a specific, small, cohort of a discipline, the author needed to take this into consideration and be careful not to generalise the findings to fit the general population.

2.8 Ethical issues and approval

Potential ethical issues were considered since participants were colleagues of the researcher/author. Conducting focus groups could elicit pressure from colleagues for the author to participate, thereby involving the author as an insider researcher. This potentially could have implications for the outcome of this qualitative research as it may introduce bias. It has been argued that being an insider (someone who belongs to the group of the participants being studied) or outsider (someone who is not a member) may have consequences within the context of qualitative research. Asselin (2003, p, 100) posited that as an "insider researcher, one shares an identity, language and experiential base with the study population" and therefore may find it less difficult to recruit participants and have greater opportunity to facilitate open discussion. This is somewhat true in this case as it has allowed for robust data to be obtained during the focus group sessions among the GP registrars. However, an

awareness of this prospect with appropriate balance of personal involvement and a clear explanation as to the nature of the study allowed for elimination of this ethical factor.

Consequently, no serious ethical concerns were encountered in this research. A low risk ethics form was completed appropriately prior to the commencement of the project with subsequent approval from the Ethics Committee. Participants were rightly given the information sheet and consent forms and reminded that if they wished to withdraw there will be no negative implications for their training or education. Copies of the ethics approval letter, information sheet and the consent form have been included in the appendix section.

2.9 Timeline:

The research was conducted with due regard to submit the project within the deadlines. The period of proposal submission to the final research submission is approximately eight months. The initial task was to inform the Education Department and the Education Programme Director that the research was to be conducted. In November, the research proposal was submitted inclusive of the ethics form for approval.

In December, the feedback for the proposal was obtained and the ethics approval was gained. The approval from the Programme Director (see Appendix section) was

also obtained before the recruitment of participants began. The recruitment commenced in February as anticipated and continued until March. All the GP trainees were given the information sheet and asked whether they wished to be included in the research. Written consent was appropriately secured.

Although the research proposal suggested an earlier time for data collection, this did not start until March. The collection was completed over four to six weeks to enable adequate contact with the participants and to also allow sufficient time for the planning and organisation of the focus group discussions. Judicious use of time enabled additional research instruments to be used for data collection, such as semi-structured interviews. This was the plan employed in the event of poor response or participation from the focus group session, or if the initial data collection method did not yield the adequate amount of data needed for subsequent analysis.

Transcription of the data was carried out concurrently with collection and often immediately afterwards so that ample time could be dedicated to a thorough thematic analysis of the responses. In April and May, a comprehensive literature review was conducted to explore how this relates to the findings from the research and the writing up process commenced. This allowed sufficient time to prepare the findings for presentation In June. Feedback received during the presentation then assisted in fine-tuning any details for the research to be ready for final submission in July.

In summary, a qualitative method using an inductive research approach was used to generate data. This approach appears valid for this type of research as it allows new themes and concepts to be generated. It proffers the opportunity to use participants' ideas to develop answers. This was essential because the answers must relate to their experience and perception of reflection in the GP surgery. The unique nature of an individual's perception is vital to be harnessed for the interpretation of this study. The combination of two research tools (focus groups and semi-structured interviews) encouraged a robust data collection and eliminated any problems that may have ensued from a lack of or inadequate response.

There were 30 general practice registrars, of whom 10 were involved in the study. Given the amount of data and information obtained from the participants and the manner in which responses reinforced one another, it does appear that the involvement of all 30 Registrars would not have been absolutely necessary. Although it may be argued that it could have offered more credibility and validity, it does not seem to wholly affect the integrity of this project.

CHAPTER 3: RESULTS

In this section, the findings of the analysed data are explained. These findings have been presented in sections based on the research questions being asked.

Some aspects of the results have been presented in tables and diagrams to facilitate easy reading.

RESULTS

Throughout the process of organisation of the question guides for the focus group and semi-structured interviews, the data collection, and the data analysis, the research question and the sub-questions remained at the forefront of the researcher's mind. This was essential in order to adequately and sufficiently provide answers to the research question.

The research question and sub-questions will be seen here again for the reader to create an ongoing understanding of the research questions and how the results relate to the questions being raised. These sub-questions have been used as the headings that showcase the results.

What is the perceived value of video-recorded consultation as an educational tool in aiding self-reflection in a General Practice setting?

The Sub-questions are therefore:

1) What is the significance of self-reflection in General Practice?
2) What is the perception of video consultation as an educational tool in a general practice setting?
3) How can video consultations help in fostering an opportunity for good self-reflection?
4) What is the difference in the quality of self-reflection with and without the use of videos?

This has been divided into four sections based on the sub-questions of the main research topic. The first section displays the results of the focus group and semi-structured interviews as they attempt to answer the first sub-question on the relevance and perception of self-reflection in General Practice. The second section showcases the emerging themes from data that analyses responses to the second sub-question on the educational value of video consultations within a GP setting. The third section will highlight the results that show how video consultations foster self-reflection. The final section will reveal the opinions and responses of the trainees on whether the quality of self-reflection can change with or without the use of video-recordings. For the purpose of identification of individual trainee responses, the participants for the focus group session have been named as trainee R1 to R6 respectively whilst the participants involved in the semi-structured interviews were recognised as trainee (INT1) to trainee (INT4) respectively.

3.1 What is the significance of self-reflection in general practice?

The trainees gave several reasons why they found the process of self-reflection relevant within general practice. Most of the participants from the focus group identified reflection as a learning opportunity and these were further broken down into different areas. Trainee R3 reported that reflection offers learning from one's own consultation whilst interacting with the patients and that this also fosters learning from other people, for example, the patient. Trainee R4 added that reflection offers learning from one's own mistakes. Trainee R2 further commented that reflection is important to enable identification of knowledge base and areas for

improvement. It was pointed out during the focus group that through the reflection, there can be an increase in self-awareness where a doctor becomes more familiar with themselves and their own emotions. Another trainee R1, mentioned that the process of self-reflection can be quite therapeutic.

An enquiry into what prompts self-reflection in a GP setting yielded answers that demonstrated that the types of cases seen during surgery can stimulate a GP to reflect (See table 2). Examples given were: interesting cases (trainee R1); complex or challenging cases (trainee R1); or in fact cases that result in a negative impact on the doctor (trainees R1 and R3). For some trainees, it may be a clinical case they have managed successfully (trainee R5) and for another it is the type of clinical encounter that evokes a particular emotion (trainee R6).

A further motivation for reflection has been identified as uncertainty. When a doctor is uncertain about their decisions on the action or management plan in regard to a patient, it may help the doctor to reflect (trainees R1, R4 and R6). Whilst the trainees agreed that uncertainty in making decisions is a major trigger for reflection, Trainee R6 further commented that this uncertainty can also be exhibited in checking the validity of the decisions that have been made already.

Trainees R1 and R5 identified knowledge gaps as another reason why doctors reflect in general practice whilst some trainees (R2, R6) thought that reflection is a natural

process and individuals who are naturally reflective or who engage in religion that encourages reflection will spontaneously reflect irrespective of prompts or triggers that may co-exist. Trainee R1 added that feedback following a consultation influences the process of reflection for some doctors.

The question of how doctors reflect on a daily basis and in their professional capacity elicited a variety of responses. Trainee R5 said "reflection is such a broad term and we all do it in our own way". Trainee R1 mentioned that "*basically all of our interactions, every single day has a degree of self-reflection in it*". Furthermore, trainees identified different methods by which they can observe reflection. The first is through conversations (trainees R4, R5 and R6). They iterated that the easiest way for them to reflect is when they speak to other people about the past events. Some trainees (R2, R4) found that writing down their thoughts and outcomes of their critical thinking is very helpful. This could be in the form of a private journal or on the e-portfolio that all GPs are encouraged to keep.

The mention of the e-portfolio brought a lot of discussion to the table, with many of the trainees expressing reservations. Despite this, some commented that even if it is disliked, the e-portfolio still has a place and benefit in the training of GPs or doctors in other disciplines. Table 1 below is a summary of the advantages and disadvantages of the e-portfolio that were noted.

TABLE 1: The advantages and disadvantages of the e-portfolio as a method of reflection

Advantages of e-portfolio
• Required for training needs (Trainee R6) • Method for standardising (Trainee R5) • Prompt for reflection (Trainee R6)

Disadvantages of e-portfolio
• Too structured; not flexible (Trainee R4, R1, R2, R5, R3) • Feels fake (Trainee R4, R6, R2) • Not realistic (Trainee R4, R1) • Feels forced (Trainee R4, R1, R6, R3) • Concerned about who is reading (Trainee R4)

A few of the respondents (trainees R4 and R5) commented that they like to reflect by receiving feedback on their consultations and then talking about it or writing it down as required. Generally, there was a consensus among all the registrars that the way they are expected to reflect, as compared to what might motivate them to reflect, often differs. Trainee R1 said ''*[They] want you to have specific learning outcomes…and sometimes, it is not as easy, and it is not quite clear what you have learnt or experienced*'.

An in-depth questioning based on the already developed themes on perception of self-reflection was carried out via semi-structured interviews. These yielded similar results and at the same time helped to identify additional ideas and perception. As a complement to already identified responses on the relevance of self-reflection in general practice, the interviewees recognised reflection as a means to identifying

knowledge base (INT1, INT4), areas for improvement (INT 1, INT4), opportunities for ongoing learning (INT3) and self-development (INT1, INT2, INT 4). One trainee mentioned that is a useful process for developing coping strategies (INT1).

Regarding prompts for self-reflection, the responses were quite similar in reiterating that it could be a natural occurrence for certain types of individuals and personalities (INT1) and that different types of cases could provide a trigger. These could include cases influencing a doctor positively (INT1) or negatively (INT4) as well as emotionally laden ones (INT, INT4). Knowledge gaps (trainee INT3, INT4) and opportunities to watch other people evoke self-reflection in certain doctors. Interestingly, a trainee (INT4) commented that critical or significant events may often be prompts for self-reflection. These findings have been summarised in table 2 in the next page.

TABLE 2: OVERARCHING THEMES FOR WHAT PROMPTS SELF REFLECTION

OVERARCHING THEME	**SUB-THEME**
TYPE OF CASES	- *Weird and Interesting clinical cases(R1)* - *Challenging (complex) and/or causing a negative impact (R1, R3, INT4)* - *Successful cases (R5, INT1)* - *Emotion evoking and certain life events (R6, INT1, INT4)* - *Significant events (INT4)*
UNCERTAINTY	- *In making decisions (R1, R4, R6)* - *Checking validity of decisions (R6)*
KNOWLEDGE GAPS	- *(R1, R5, INT3, INT4)*
NATURAL PROCESS	- *Can be influenced by religion or personality (R2, R6, INT1)*
FEEDBACK	- *Watching others (INT2)*

The trainee also corroborated findings from the focus group regarding how they like to reflect as doctors. Most trainees (INT2, INT3 and INT4) admitted that their best reflections were from conversations on a daily basis (INT1 and INT4) with minimal distraction (INT4). Trainees INT1 and INT4 preferred to write down their reflections.

3.1.1 What makes a good self-reflection?

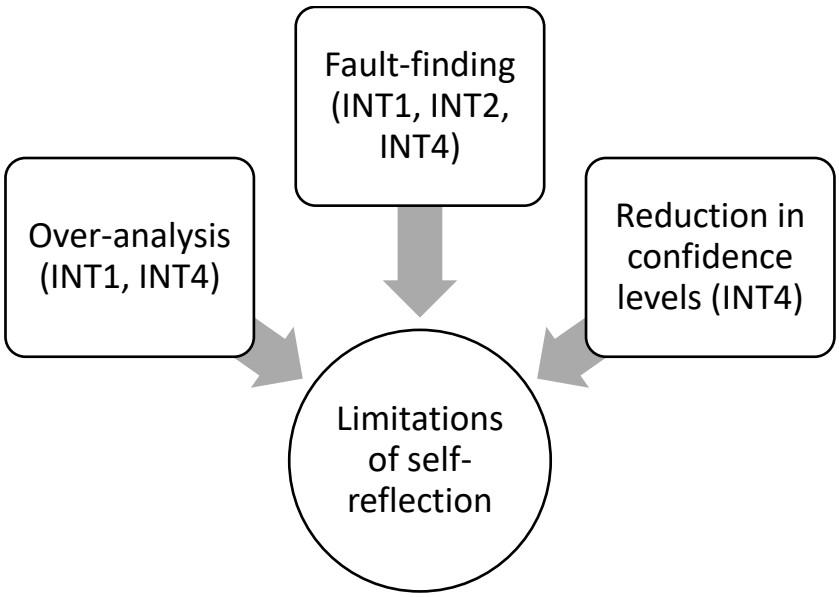
This question was presented during the interviews. The opinion of the trainees was that a good self-reflection is one in which a doctor can be honest about themselves and take their emotions into account in concluding how they truly feel about an event. Another trainee opined that a good reflection is one that provokes learning and identifies areas for improvement. INT4, however, thought that a good self-reflective process is one that helps a doctor to develop new ways of working or achieving goals.

3.1.2 The benefits and limitations of self-reflection:

To expatiate more on how self-reflection is significant or relevant to general practice, the trainees were asked how self-reflection has benefited them during their careers. This generated responses such as improved communication with patients (INT4, INT2, INT1), chances to develop new ways of working and achieving goals (INT4, INT1), improved clinical skills (INT2, INT1), increased confidence (INT1), and overall a better patient outcome (INT1).

Even though self-reflection was praised as a good exercise that all doctors should imbibe, the trainees were also quick to express their views on the limitations of self-reflection. These are presented in Diagram 1.

Diagram 1: Limitations of self-reflection



3.2 What is the perception of videoed consultations as an educational tool in a general practice setting?

3.2.1 The relevance of videoed consultations for teaching in general practice

Responses from the focus group and interviews helped to identify common themes that represent the use of video-recorded consultations in education. All trainees unanimously agreed during the focus group session that video recording of their consultations had improved their communication skills and ultimately enhanced their consultations. They believed that real-time recording of their consultation had helped them to pick up on non-verbal cues from patients - a significant factor in GP consultations. Trainee R1 found that video consultations have helped "*to spot mannerisms [in myself] that may need changing or which is not helpful for the progress of the consultation*".

Trainee R5 mentioned that video consultation is a "*powerful learning tool as it has become very useful for exam preparation*", especially the Clinical Skills Assessment (CSA) component of the Membership of the Royal College of General Practitioners examination. This exam focuses on and assesses the clinical skills of the doctor within a GP environment under time constraints (Trainees (R1, R2). Trainee R1 mentioned that the use of video as part of his training supported by his educational supervisor assisted him to learn new strategies in consultations that contributed to success in his CSA exam.

The role of video in giving feedback in general practice featured strongly in the answers obtained from the trainees. Trainees R1 and R2 commented that video-recordings are not only useful when watched to generate self-feedback but can also be watched by a peer. The video-recording of the trainee's consultations can be watched by their trainers as well (educational supervisors) who can then offer comments on aspects of their practice that need improvement. Trainee R1 commented that feedback on video consultations during discussion or patient reviews in certain sensitive areas, such as mental health or gynaecology, may be limited.

Lastly, trainee R5 commented that video consultations have been useful for measuring one's progress from the start of the registrar year to the end. By capturing a consultation on camera, it is useful to watch again later to monitor changes in the trainee's clinical practice. Trainee R5 picked out videos of consultations conducted

earlier in her general practice training and compared these with latest ones. This response was equally supported by trainees R1, R6 and INT1. Trainee R5 mentioned that this was used by her trainer to monitor her progress during training. She commented that "*I have to re-watch my videos now. It is amazing to see the difference and how I have changed now… I think video is the best way of building on your learning from what you already have*".

Trainee INT1 supported this in her interview and further commented that she compared video consultations at the beginning of her GP training, when she had more than 15 minutes to consult, with now, when she is limited to 10 minutes. They were invaluable in evaluating progress and the influence of time constraints.

3.2.2 The experience of video-recorded consultations among general practice registrars

Challenge of perception

Trainees' use of video to record consultations allowed them to directly observe their clinical practice, attitudes and behaviour when seeing patients. Trainees (R1, R5, R6) in the focus group stated that it helped them to have a good perception of how they came across to patients. Some trainees interviewed (INT1,2,3 and 4) agreed that it offers a factual observation of their personal attributes. Trainee R6 also commented that this fostered a challenge in the perception of self and behaviour when seeing patients. She noted that she hadn't previously appreciated how much she nodded

and used her hands before watching herself on video - mannerisms that she would have criticised in others. During the interview, trainee INT3 supported this by saying that she had thought herself a good listener but watching her videos revealed that she repeats questions already answered earlier in the consultation.

Another aspect, as identified by trainee R4 and R6 is the perception of patients and their mannerisms. It was mentioned that it is easy to think that patients are following the consultation and are happy with the outcome of their discussion with their doctor. However, the facial expressions or attitudes of the patients in the video suggested that their perception of the consultation did not align with that of their doctor.

The feasibility of video consultations in general practice

Many comments were made regarding the feasibility of video consultations in general practice. Trainee R3 suggested practical difficulties often make it difficult to set up a video-recorder. Once that hurdle was overcome, the ongoing process itself was also fraught with technical difficulties and help was often required to keep the video up and running. It was expressed that this can be quite challenging during a busy surgery and that it can be arduous to obtain consent from patients for the videos. This was supported by trainee INT4 who often found that obtaining consent in the middle of surgery when the patient may have started talking was disruptive to the normal flow of the consultation.

The acceptability of video consultations in general practice

Responses from the focus group (trainees R1, R3, R4, R5 and R6 included words and phrases such as "*I hate it*" when asked how they felt about being videoed when reviewing patients. Trainee R1 found it "*unpleasant*". Other answers included the fact that the trainees R2 and R3 found it "*very unnatural*". Some trainees (R3, R4 and R5) described the process as "*fake*". Trainee R6 felt it was staged and trainee R1 chose the word "*annoying*" in her response. She noted that her voice sounded different and exposed her weakness and lack of self-esteem when reviewing how she had perceived herself. Most of the trainees found their videoed consultations uncomfortable to watch – trainees R1 and R6. Not all of them were negative about whether it was acceptable. Trainee R6 mentioned that despite the factors that may influence her negatively from using videos, there is no other direct method by which her ingrained bad habits could have been identified as these could not be hidden from the camera.

The validity of video consultations in general practice

The capacity of videos to realistically show how events have unfolded, or in this case how consultations have been conducted, has been perceived by trainees R5, R6 and INT2 as matchless compared to other forms of feedback. Trainee R6 mentioned "*It is the best teacher…you see yourself how other people see you. To me that is quite powerful*". Trainee R2 mentioned that being videoed "*was one of the turning points that helped me change my practice*". Trainee R1 further commented that *"… so again, my gaps in knowledge, complexities, uncertainties and my consultation skills is*

what I found videos best for". Trainee INT4 commented that videoing consultations offer a good insight. All the trainees in the semi-structured interview praised the ability of videos to improve communication skills for the doctors, especially non-verbal ones.

The drawbacks of video consultations in a general practice setting

Trainee R5 asserted that knowing that the video is there can tend to change the attitude and practice of the doctor, and that this could be equally said of the patient. According to trainee R2, patients begin to behave in a certain way when they know they are being recorded on video.

A further point raised during both the focus group session by trainee R1 and trainees INT1, INT2, INT3 and INT4 was that recording videos of patient consultations causes "*performance anxiety*". This was remarked on as a problem and a limitation. Trainee R1 further said that there was a heightened risk of making errors.

According to trainees R1, R6 and INT1, certain sensitive cases such as in the area of mental health or intimate examinations, cannot be videoed and are therefore not suitable for teaching and feedback. Interestingly, trainees INT1 and INT4 mentioned that watching their already videoed consultations can often feel like torture. This has been noted by both trainees especially in situations where the consultation did not evolve as expected.

3.3 How can video-recorded consultations help in fostering good self-reflection?

The question of how videoed consultations can help in fostering self-reflection elicited a variety of responses among the GP trainees. Trainee R1 felt that videoing consultations aids recollection of events. During the semi-structured interviews, trainees INT1, 2, 3 and 4 commented that they felt that it serves as a memory store of past events or consultations that have taken place. On the same note, it was suggested by trainees R1, R5, R6, INT1, INT2, INT3 and INT4 that using video helps to prompt the reflective process in the first place.

Videoed consultations were perceived by all trainees as offering objectivity in their self-reflection. They believed that they allowed an objective perception of themselves in relation to their attitudes, mannerisms and behaviour, as well as for their patients. All the trainees during the focus group agreed that videos are very useful in reviewing what was done well and what was not done well and that this was an essential component of reflection. Trainee INT3 mentioned that it can remove any personal bias that the doctor may have during reflection. Trainee R2 further commented, "*I learnt and saw things that I don't think would have come out in any other format*".

All the trainees commented during the focus group and the interviews that video consultations assist in identifying elements from their daily consultation in clinical practice that they may reflect on. These include gaps in knowledge (trainee R5),

human complexities and the impact on consultation (trainee INT1), non-verbal communication skills (trainees R1, 2, 3,4,5,6 and INT1, 2, 3, 4) and critical events (trainee INT2).

An important detail mentioned (by trainee R6) on how video consultations aid reflection is that they provide structure for the doctor as opposed to abstractly developing ideas or elements. In addition, trainees R6 and INT4 mentioned that using video helps to consolidate the process of feedback, especially as it offers the opportunity to be watched by someone else. It was argued by this trainee that this allows another angle for self-reflection that might not otherwise have been thought about.

Lastly, trainees R4, R5, INT1, INT2, INT3 and INT4 all surmised that video consultation, due to its graphic nature, can be watched again and again providing a reference for another self-reflective event in the future. They discussed that when watched at a later date and time, a trainee may then find something different from what was reflected on in the past and choose to review this from another point of view.

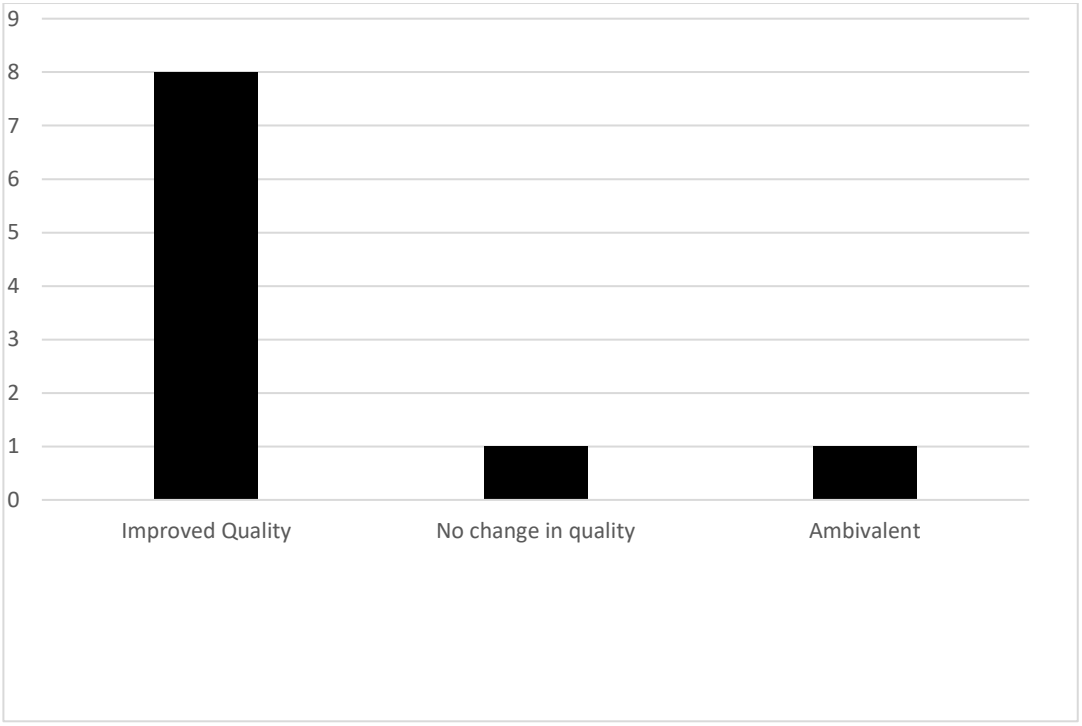
3.4 What is the difference in the quality of self-refection with and without the use of videos?

One trainee (INT1) believed that there was no difference in the quality of the self-reflection with or without the use of the video, commenting that as "*a naturally reflective person, using videos do not make so much of a difference in the quality*". This was partially supported by trainee (INT4) and has been represented by an ambivalent perception in Graph 1. This trainee felt that although the overall quality does not change, using videos "*may generate a different angle for reflection that a doctor may not have thought of*". Other trainees (R1,2,3,4,5,6, inclusive of INT2, INT3) during the focus group session and interviews iterated that the quality of the reflections evoked by watching videos were particularly significant, especially when observing non-verbal communication skills. Trainee INT1 volunteered that the quality of a reflection is not improved simply by watching videos of previous consultation, but it does occur as a product of a learned exercise and experience with time.

Trainee INT1 further concluded that the quality of self-reflection may be enhanced using videos based on whether the trainee is a visual learner or not. It was said that ''*The learning style of an individual can be used to help a person to develop reflective skills that they are naturally inclined to''.* It was suggested that trainees who naturally like to record in writing may not be reliant on using videos to aid self-reflection even though it may be useful. However, visual learners may use videos as an aid for self-reflection as they are naturally inclined to this.

The relationship between self-reflection and one's learning style was explored during the semi-structured interviews. As trainee INT3 mentioned, '' *I like to write things down and I remember which helps to reflect...It aids my recall afterwards...My learning style probably impacts on why I don't find videos personally helpful in improving the quality of my reflection as I prefer to hear and write things down for my reflection than watch'.* Trainee INT4 held a different view. In this case, she opined, ''*I am very visual and that is why reflections stay with me. It is very painful and generates anxiety. When I reflect with videos, it makes the experience more painful especially when things have not gone well'.*

Graph 1: Perception of differences in the quality of reflections with and without the use of video



CHAPTER 4: DISCUSSION

This section offers a description of the study's key findings as they answer the research question.

Here, an interpretation of the findings with an insight to how these relate to a wider theoretical framework is provided.

It also includes the limitations of the study.

DISCUSSION:

The discussion of the study has been divided into sections similar to the themes used to explain the results.

4.1 Perception of self-reflection in a GP setting

Reflection seems to have become a concept in almost every aspect of life or professional discipline. Many researchers (Kolb (1984) and Schon (1983)) have explored different aspects of reflection, from its epistemology and pedagogy, to relevance in practice and in self-development (Gustafsson & Fagerberg, 2003), and its influence on professional behaviour (Mudde, 2015). Another study (Thorpe and Barsky, 2001) has shown that self-reflection offers opportunities for learning and self-development. This will explain why the findings from this research consolidate the previous assertions on reflection. All trainees agreed that self-reflection in general practice is an essential component and described its several opportunities for learning. These range from learning from self and from others through conversations, to also learning from one's own mistakes. The trainees reported that they often used reflection to identify knowledge gaps and also to identify areas for self-improvement and within their professional practice. They were able to also identify what triggered the reflections in the first place. Some trainees argued that even in the absence of prompts, a naturally reflective individual will still be able to benefit.

The natural ability to reflect may stem from a person's personality, and how well one reflects may be dependent on experience. One trainee who felt that reflection is integral to her daily living mentioned that she found the process quite therapeutic. This was an interesting point and was further reviewed to identify studies that may have looked into the therapeutic power of reflection. The study by Thorpe & Barsky (2001) researched the concept of healing through self-reflection, finding that where this occurs in a professional setting it is heavily dependent on interaction between values including spirituality, self-awareness and critical analysis. One trainee specified religion as a vital component of his reflective process. It may then appear that reflection fosters healing, as individuals are able to accept some things they are unable to change and through that develop themselves to embrace their imperfections and continue to strive towards best practice when another similar opportunity presents itself. This provides another insight to reflection in general practice. As GPs regularly have contact with many people during the day, it is vital that they develop techniques to cope with all the challenges that come with their demanding job. Self-reflection may well offer that advantage.

The question of what prompts people to initiate a reflective process is pertinent. Most trainees are prompted to reflect when they feel that a consultation has not proceeded well. This is similar to the findings from a study by Gustaffson & Fagerberg (2003) They looked at what prompted registered nurses to reflect. During their interview, they discovered that the nurses paid attention to cases where poor nursing care had been identified. Similar responses emerged in the study when the

researchers recognised that uncertainties in decision making or a management plan also prompted reflections. This may be because as human beings, when we do very well we do not tend to review how or what we did to contribute to the success. On the other hand, we may tend to analyse when we feel a task or project was not well done in order to improve the experience for a later time.

To improve the outcomes of their clinical practice, the trainees discussed the value of conversations among colleagues or peers as a way of reflection. This is not a new finding as Gustafsson and Fagerberg (2003) equally discovered this from their nurses. Their study described this as "mirroring" and found that participants gained much benefit from meeting one another after nursing care to deliberate on their experience. They described this as "reflective conversations". This is often not the case within a general practice setting, however; most doctors interviewed expressed their frustration at being expected to reflect by writing in the e-portfolio, which itself is subject to tight restrictions and eliminates the advantages of reflective conversation. One trainee commented that reflection should be easy, relaxing and enjoyable. According to one of the doctors: "*It just tells you how much easier it is to reflect if you relax. And not worrying about who is listening'*.

Several similarities have been found between results revealed in this project and the study conducted by Gustafsson & Fagerberg (2003), although their participants were registered nurses working in a similar setting and the methodologies were very different. Theirs was a small but in-depth study with recruitment of a minimal

number of participants using a phenomenological (seemingly contemporary) qualitative research methodology. Again, this is different to the approach used here.

The pedagogy underlying this research work, as mentioned earlier in the literature review, is the principle of Schon (1983) as seen as in "reflection in-action; reflection on-action". It appears that most of the trainees have represented the ideology that much of their reflection takes place after a consultation, which fits well with the *on-action* component of Schon's work. The trainees also mentioned numerous times that the outcome of these reflections then determines how a new situation or a recurring one may be approached differently. Although Schon's work has been accepted widely and is highly respected, it appears that the philosophy needs to be critiqued adequately as supported by Greenwood (1993). It may be more accurate to say that Schon's work could appear incomplete if there is no "pre-action" aspect of his reflective cycle.

One may look at this in a different light: if a doctor reflects to improve their practice, there must be some abstract thinking and conscious decision taken with regard to a future event, whether in the form of a decision to perform a task in a different way or to avoid a certain attitude. This is reflection "pre-action" which may then be reflected upon again "*in-action*" and then "*on-action*". It may be argued therefore that Schon's work could have been described more robustly in this manner. This assertion has been well highlighted in the responses given by the registrars during the focus group and semi-structured interviews.

The significance of self-reflection in improving learning, self-awareness, healing, communication skills, clinical practice and professionalism in general practice has been discussed. However what role does video-recording play in this field? The next section will discuss the perception of general practice trainees on video-recording of their consultations.

4.2 The use of video in a GP setting

There have been numerous studies to highlight and review the use of video to enhance learning. Teaching is one of the disciplines to have embraced this concept and showed great interest in research. This can be seen in the work of Stockero (2008), Pellegrino & Gerber (2012), Ajayi (2015), Hollingsworth & Clarke (2017) and Hunukumbure, et al. (2017). However, research to review real-time GP consultations is scarce (Eeckhout et. al., 2016) and it is therefore even more challenging to find studies dedicated to exploring the influence of video-recording consultations on self-reflection. Eeckhout et. al. (2016) seems to be the first study that displays the most significant resemblance to this research work. This is because the participants in their study were GP registrars and the focus of their study was on the acceptability and feasibility of real-time video consultations in a GP setting. It was clear in their literature review that there is paucity of research work around this area, which is a finding the author will agree with.

Despite the awareness of the scarcity of previous research work, the study carried out by Eeckhout et al. (2016) has offered an insight into the perception of their GP

registrars and, therefore, to the data with which one can make comparisons. It is pertinent to focus on the study carried out by Eeckhout et al. (2016) on the use of video in real-time consultations. There is some correlation in the research approach across their study and this research work. Both have used descriptive cross-sectional methods with purposeful sampling and grounded theory as a basis for qualitative (thematic) analysis of their data. This may ascribe some validity to the research approach as there have been consistencies demonstrated in both studies. In contrast, however, is the choice used in data collection. Eeckhout et. al. (2016) chose to use questionnaires to generate quantitative data and free text boxes for qualitative data. This would seem appropriate and feasible for their study, given the high number of participants recruited. Nevertheless, the outcomes from both studies have offered some assurance that the perception and experience is similar, despite covering different regions and different individuals. The benefits and the limitations of video use in general practice are largely complementary for both studies.

According to both studies, the perception of trainees on the use of videos in a general practice setting is quite divergent. Such divergent opinion is not unique to this work, as it does bear likeness to the outcome of studies carried out by Eeckhout et al. (2016); Nilsen & Baerheim (2005). The latter study explored this concept amongst medical students. The results from this project show that there are numerous benefits to recording consultations by video in a GP surgery. Summatively, these include the opportunity to provide factual, real-time observation and objectivity when reviewing a consultation; improved communication skills;

identification of negative or inappropriate attitude; provision of useful feedback for change in clinical practice; and recognition of previously unnoticed practices. Nonetheless, some of the trainees felt strongly that their experiences of the use of videos limit their desire to incorporate them into their daily clinical practice.

Trainees' experiences with using video-recordings within a high-stake setting generated disparate opinions, and reservations made their use less feasible and less acceptable on a regular basis. About 80% of trainees used phrases such as "I hate it" and "it is very unnatural", to express how they feel. Many also expressed discomfort that the presence of video tended to change the atmosphere of the consultations as both patient and doctor are aware that they are being recorded. They reported that occasionally an uncomfortable atmosphere can heighten anxiety, thereby impacting on clinical decision making. And that videoing consultations in general practice is different and comes with its own different barriers. These set it apart from other disciplines. These experiences are unique to general practice since doctors are dealing with real life, with real people who have real health concerns. The trainees' perception or experience of video as part of their professional practice will not equate to and cannot be similarly observed by teachers or other users of video as a tool for enhancing teaching, feedback and reflection because the environment is different.

4.3 The perception of videoed consultations as an aid for self-reflection

Reflection is a process that can be interpreted in different ways depending on individual engagement. GPs are expected to reflect and write down their reflections to support self-awareness and self-development, and to have as evidence in continuous professional development. Every individual has the ability to reflect and look inwards to identify areas that require attention and possibly change.

Luft & Ingham (1955) has described the Johari window. This represents how individuals may interpret how they are or how people see them. This provides an explanation for how people may perceive themselves and how they may be able to recognise weaknesses in themselves that they may have otherwise not seen or that other people have not helped them identify. The most significant part of this window is the "unknown unknown" window. It is worth mentioning as this part of the window represents attitudes and ideas about an individual that they are blind to and which other people are also unaware of. These may not necessarily be unpleasant or undesired but could represent a significant part of an individual's makeup that requires attention. In a way, if discovered, it could offer a potential avenue to give insight into self-perception and thereby improve self-awareness and self-development.

Consequently, GPs may also apply this concept within their clinical setting. As earlier iterated, communication between patient and doctor presents challenges. This may be because a doctor is not aware of certain mannerisms or expressions that may be damaging to the successful outcome of a consultation. Or, on the other hand, a

doctor may be oblivious of excellent skills they portray when they see their patients. This is therefore the doctor's "unknown unknown" and a better understanding of this through refection may be relevant for improvement.

There are three ways in which one could gain a deep insight into this "unknown unknown" window: observation by others; discovery by the individual involved; and a shared discovery by the individual and someone else. Video is an educational tool that can be used to capture these in the natural state of occurrence. As identified by the trainees, video offers real-time recording of consultations and provides objectivity, opportunity for feedback and reflection.

According to Harris et al. (2005), cited by Hollingsworth (2017, p.463), "*video case studies capture visual, non-verbal, physical, tactile and verbal elements*". They are very useful for developing an accurate perception of how one comes across to other people. The same can be said for their ability to challenge any pre-existing perception as already identified in the results section of this study. An interesting study was carried out by Dunning & Kruger (1999) highlighting that erroneous perceptions can mask how an individual is seen by others. The study found out that some students had assessed themselves as scoring higher marks than the reality. The students who rated themselves with medium-level scores either scored the same or higher than they had predicted. The perception someone carries of him or herself may be genuinely flawed and a video can offer some truth towards challenging a misperception, leading to genuine self-discovery. One may argue otherwise that an

individual who may be truly lacking in self-awareness may not observe any flaws when watching a video of themselves. However, when such videos are watched by someone else, they may then be guided towards true self-discovery.

This can explain why the trainees felt that video-recording gives a deep insight into the nature of their consultations by showing the true picture of what happened and how events unfolded. It offers the opportunity for factual recall whenever it is needed and offers a basis (structure) for reflection. It can be used for reference when required and can trigger a reflective stance for the doctor. Compared to other forms of feedback for the registrars, video appears to be the only tool that is able to reveal the reality.

Although there was not a consensus among the trainees on the benefit of video for reflection, one may argue that it does have significance overall. Trainees linked reflection with using the e-portfolio, the limitations of which they did not find useful as they were asked to write down their reflections in a very structured way. The perception by trainees to support this was expressed in Table 1. This presents a significant barrier to the connection between video-logging of consultations and reflection. A doctor who is given a template to reflect on, and who is also required to develop learning needs and action points at the end of a reflective process, begins to see this as a chore and may not engage with it adequately.

However, if one sees reflection as a means to developing and improving self consciously or unconsciously, without necessarily writing down in a rigid format or without expectations or fear of who may be reading the content, then the impact of videos on self-reflection especially in general practice setting is immense. Another way to view this is that if reflective conversations were to be introduced, the perception of the trainees on self-reflection in GP setting may be different as the reflective process here is somewhat different and flexible.

4.4 The perception of difference in quality of self-reflection with and without videos.

To further expatiate on the impact of video-recordings on self-reflection, the trainees were asked whether there was a difference in the quality of reflections when videos were watched as compared to when videos were not used. There were disparate views on this, reflecting the manner in which the reflections are required to be presented. Whilst some of the interviewees felt that there was no difference in the quality, as a doctor's experience or personal ability to reflect would be the determinant, other interviewees felt that the quality of their reflections on their non-verbal communication skills was greatly improved.

The ability of filmed consultations to improve the quality of reflections based on non-verbal communication skills did not come as a surprise as throughout this study, the objectivity video adds to a consultation has been highly emphasized. On the other hand, it was mentioned that videoing consultations does not directly improve quality

but could offer a different angle to the reflective process at a later time. In addition, it was also discussed that quality of the reflection may not bear any credit to videoing and that this is thoroughly based on person's level of experience which can be acquired through years of constant practice.

The learning style an individual possesses was also called into play as a reason for why filming consultations does not necessarily affect the quality of self-reflection. Visual learners facilitate learning by ''watching'' or ''seeing'' and some learners prefer to write down. Whilst ''visual-learning doctors'' may benefit from watching videos of their consultations to aid reflective opportunities, ''reader-writer learning doctors'' may struggle with this concept. Similarly, ''visual-learning doctors'' may agonise over filmed consultations that have gone badly as they are able to remember vividly the events of the consultations that they wish they could have done or handled differently.

The ambivalence expressed from the use of video for determining the quality of one's reflection however, has probably emerged from individual preferences and personal experiences or attributes. One could have erroneously thought that due its objectivity and validity, videoing consultations automatically leads to improved quality of self-reflection. A hypothetico-deductive research approach may have favoured this assertion quite easily as it endeavours to explain themes to fit into a known fact. However, by carrying out this study with adequate consideration for personal perceptions and experiences, it has allowed for a more exhaustive response

to this question. Thereby, consolidating the reason why an inductive research approach is ideal for this evaluation study.

In hindsight, this was quite a challenging question to answer because there was no definition of what helps in measuring the quality of reflection. The author could have been clear in this study by asking whether there was improved quality of reflection by being able to identify learning needs from a reflective process, or whether by reflecting with videos there was an improvement in clinical practice. The question of quality and whether this will amount to improved clinical practice may the focus for further research work or study.

CONCLUSION

This study aimed to look at the perception of video-consultations as an aid to self-reflection in a general practice setting.

What is already known about this topic varies between disciplines. Generally, video recording of any event offers good insight and acts as a highly useful resource for feedback and reflection. Video recording of consultations is quite beneficial for reflection and serves as a better aid as objectivity is key. Although the use of video recording has been explored thoroughly in teaching and simulation, very few studies have explored its applicability to real-time consultations general practice.

From the limited studies reviewed in this research piece, the benefits of video-recording consultations as an aid to self-reflection is similar to the benefits when used in a different capacity. It has been identified as a tool for improving communication skills and thereby improving clinical practice. Its use in general practice as an aid for self-reflection, however, is not widely popular.

What this study adds to the already existing literature is that it has the capacity to challenge doctors' self-perception, prompting self-awareness and self-development whilst also placing the responsibility for learning and professional development with the doctors themselves. In addition, video recording promotes self-reflection by offering objectivity, recollection and true feedback. There are, however, many co-

existent factors, such as the professional environment, that limits its potential. This is due to the peculiar nature of the setting of general practice where patients need to be seen within a set timeframe. The acceptability and feasibility of video was found to be very poor in general practice. Nevertheless, it may be useful to think that if resources are put in place and the environment is made conducive, video-recording of consultations may be better received.

Although the benefits have been iterated, there is no study that actually measures the true outcome of the impact of video-consultations within the general practice setting. This study superficially touched on whether the quality of reflections is improved, but the response within this study is not adequately comprehensive to fully define its outcome. Likewise, the question of whether watching video-recorded consultations can translate to improved learning outcomes needs further work.

Lastly, it is important to offer suggestions for future research. An in-depth analytical research study is acutely needed to examine the use of video consultations in a general practice setting to further corroborate or refute findings from the limited studies identified in the earlier review. In addition, research is needed to establish a relationship or connection between video consultations and improved clinical performance within a general practice setting. Hopefully, recent breakthroughs in the world of research and the increasing use of videos will make this a reality sooner rather than later.

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APPENDICES

APPENDIX A: FOCUS GROUP QUESTION GUIDE

FOCUS GROUP QUESTION GUIDE

Project Title: The perceived value of video consultation as an educational tool in aiding self-reflection in a General Practice Setting?

Sub-questions:

The Sub-questions for these shall include:

5) What is the relevance of video consultation as an educational tool?
6) How can video consultations help in fostering an opportunity for good self-reflection?
7) What is the difference in the quality of self-reflection with use of videos and without videos?

Themes:

1) Perception of video consultation
2) Perception of self-reflection
3) The interaction between the above two

Theme 1

- Opening question: I want to hear your views on how do your self-reflection.
- What prompts you to reflect on your consultation? By this I mean do you feel motivated to self-reflect because you have watched yourself in the video? Give any other reason that motivates you to self-reflect

- How are General Practitioners expected to self-reflect on their clinical practice?

Theme 2

- Opening question: I want to hear your opinion and how you feel about recording the video of your consultation with patients.
- Is it a relevant as an educational tool?
- Is it relevant personally to you? Why?
- What do you see as strengths of video consultations?
- What are the barriers you face in doing these videos?

Theme 3

- Opening question: What do you think is the role of video consultation in aiding a good self-reflection?
- When you reflect on your practice from watching videos of your consultations and from without videos, is there any difference in the quality of these reflections?
- If yes, how do these differ
- If no, please give reason why

APPENDIX B: SEMI-STRUCTURED INTERVIEW (QUESTION GUIDE)

SEMI-STRUCTURED INTERVIEW QUESTION GUIDE

4) What is the relevance of video consultations in Medical education?

5) What are the strengths and weaknesses/ barriers of video consultations?

6) How are General Practitioners expected to self-reflect on their clinical practice?

7) What is the role of video consultation if aiding a good self-reflection?

8) When you reflect on your practice from watching videos of your consultations and from without videos, is there any difference in the quality?

   If yes, how do these differ?

   If no, please give reason why?

APPENDIX C: ETHICS APPROVAL

Ethical Approval

Dear Tutu

Your ethics form has been screened with the following comments-

'Exempt from full ethical review. Doesn't constitute research as it is a service evaluation involving the use of non-sensitive, completely anonymous educational tests, survey and interview procedures when the participants are not defined as "vulnerable" and participation will not induce undue psychological stress or anxiety. All gate keeper permissions of participant access (VTS regional course organiser) will need to be sought before data collection commences - you need confirmation from the regional course organiser for the vts scheme you will be getting participants from. evidence of this would need to be included in the appendix of your final assignment.'

As long as you follow the comments provided above you are permitted to carry out your data collection.

Kind regards,

Maryanna Baston – Senior Coordinator (Postgraduate Programmes)

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APPENDIX D: INFORMATION SHEET

Participant Information Sheet For General Practice Registrars

UCL Research Ethics Committee Approval ID Number: _____

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: The Perceived Value of Video Consultation as an educational tool in aiding self-reflection in a General Practice Setting

Department: Medical Education

Name and Contact Details of the Researcher(s): Dr Adetutu Popoola; Newton Place Surgery, Faversham, Kent.

Name and Contact Details of the Principal Researcher: Claire-Marie Lindsell; RCP/UCL Regent Park, London.

You are being invited to voluntarily take part in this MSc research project. Before you decide to take part, it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether you wish or do not wish to take part. Thank you for reading this.

What is the project's purpose?

Video Consultation has been imbibed hugely by the General Practice community where doctors training to become General Practitioners (GP Specialty Trainees 3; GP ST3) and full-fledged General Practitioners are continually encouraged to video their 10-minute consultations. This is done to allow doctors to watch themselves communicating with their patients, reflect and learn from these video consultations.

The main aim of this project is to evaluate the relevance of video consultation as an aid towards self-reflection in General Practice. This is intended for the period between December 2017 and May 2018.
The objectives will be to:

1) To determine the relevance of video consultation as an educational tool?
2) To explore how video consultations can help in fostering an opportunity for good self-reflection?
3) To find out if there is a difference between the quality of self-reflection with use of videos and without videos.

Why have I been chosen?

You have been chosen to be a participant because you are a Registrar currently working in General practice setting. All GP ST3s within the East Kent has been identified as a potential participant in this project.

Do I have to take part?

It is up to you to decide whether you wish or do not wish to take part. If you do decide to take part, you will be given this information sheet to keep (and be asked to sign a consent form). You can withdraw at any time without giving a reason and without it affecting any benefits that you are entitled to. If you decide to withdraw, you will be asked what you wish to happen to the data you have provided up to that point.

What will happen to me if I take part?

You will be involved in the research by spending some allocated time in one day (for example 20 to 30 minutes) between December and February in a focus group of five to six GP ST3. This will be fixed on a Wednesday after the mandatory sessional GP ST3 teaching programme. On the chosen day, you will have conversations with your colleagues regarding the research questions and what your views are on these.

Will I be recorded and how will the recorded media be used?

Your conversations during the focus group will be audio-recorded. The audio recordings of your activities made during this research will be used only for data analysis. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

What are the possible disadvantages and risks of taking part?

There are no possible disadvantages or risks of taking part.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for participating in the project, it is hoped that this work will help to evaluate the relevance of video consultation as an educational tool and also explore its potential in aiding self-reflection compared to other ways of self-reflection.

What if something goes wrong?

You can contact the principal researcher on postgraduate@rcplondonac.uk if you have any complaints and this will be appropriately addressed. However, if you feel your complaint has not been handled to your satisfaction (e.g. by the PR or the supervisor), you can contact the Chair of the UCL Research Ethics Committee – ethics@ucl.ac.uk

Will my taking part in this project be kept confidential?

All the information that we collect about you during the research will be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications.

Limits to confidentiality

Confidentiality will be respected subject to legal constraints and professional guidelines.

Use of Deception

Research designs often require that the full intent of the study not be explained prior to participation. Although we have described the general nature of the tasks that you will be asked to perform, the full intent of the study will not be explained to you until after the completion of the study [at which point you may withdraw your data from the study]".

What will happen to the results of the research project?

The results of the research will be presented as part of completion of a Master's Thesis in June 2018. The copy of the published results will be available in the library of the Royal College of Physicians. You will not be identified in any report or publication.

Data Protection Privacy Notice

The data controller for this project will be University College London (UCL). The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk. UCL's Data Protection Officer is Lee Shailer and he can also be contacted at data-protection@ucl.ac.uk.

Your personal data will be processed for the purposes outlined in this notice. The legal basis that would be used to process your personal data will be [the provision of

your consent.] You can provide your consent for the use of your personal data in this project by completing the consent form that has been provided to you.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, please contact UCL in the first instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

Who is organising and funding the research?

This research is self-funded.

Contact for further information

Dr Adetutu Popoola, 117 Thanington Road, Canterbury. CT1 3XP

You will be given a copy of the information sheet and, if appropriate, a signed consent form to keep.

Thank you for reading this information sheet and for considering to take part in this research study.

APPENDIX E: CONSENT FORM

CONSENT FORM FOR GENERAL PRACTICE REGISTRARS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: The Perceived Value of Video Consultation as an educational tool in aiding self-reflection in a General Practice Setting

Department: Medical Education

Name and Contact Details of the Researcher(s): Adetutu Popoola

Name and Contact Details of the Principal Researcher: Claire- Marie Lindsell

Name and Contact Details of the UCL Data Protection Officer: UCL Data Protection Office; data-protection@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee: Project ID number: In Progress

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	*I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction *and would like to take part in (please tick one or more of the following)* - *a group discussion* - *an individual interview* - *a joint interview]*	
2.	*I understand that I will be able to withdraw my data up to four weeks after the interview/ focus group	
3.	*I consent to the processing of my personal information; (No specific personal information will be required in this research). I understand that such information will be handled in accordance with all applicable data protection legislation.	
4.	**Use of the information for this project only** *I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified. I understand that my data gathered in this study will be stored anonymously and securely. It will not be possible to identify me in any publications.	
5.	*I understand that my information may be subject to review by responsible individuals from the University for monitoring and audit purposes.	
6.	*I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I understand that if I decide to withdraw, any	

	personal data I have provided up to that point will be deleted unless I agree otherwise.	
7.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
8.	I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.	
9.	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
10.	I understand that I will be compensated for the portion of time spent in the study (if applicable)	
11.	I agree that my anonymised research data may be used by others for future research. [No one will be able to identify you when this data is shared.]	
12.	I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. Yes/No	
13.	I consent to my interview being audio recorded and understand that the recordings will be destroyed within 6 months after the data has been transcribed.	
14.	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	
15.	I hereby confirm that: (a) I understand the exclusion criteria as detailed in the Information Sheet and explained to me by the researcher; and (b) I do not fall under the exclusion criteria.	
16.	I have informed the researcher of any other research in which I am currently involved or have been involved in during the past 12 months.	
17.	I am aware of who I should contact if I wish to lodge a complaint.	
18.	I voluntarily agree to take part in this study.	
19.	Use of information for this project and beyond I would be happy for the data I provide to be archived at the Royal College of Physicians Library, London. I understand that other authenticated researchers will have access to my	

	anonymised data.	

If you would like your contact details to be retained so that you can be contacted in the future by UCL researchers who would like to invite you to participate in follow up studies to this project, or in future studies of a similar nature, please tick the appropriate box below.

	Yes, I would be happy to be contacted in this way	
	No, I would not like to be contacted	

Name of participant	Date	Signature
Researcher Date	Signature	Signature

APPENDIX F

APPROVAL FROM THE POSTGRADUATE MEDICAL EDUCATION DEPT

Dear Tutu,

I am so sorry for not getting back to you sooner.

This project has my blessing and that of the Area Patch Dean of HEEKSS.

Kim and I do caution the potential risk of loss of anonymity of videoed patients when GPSTs are in the focus groups but are sure you will establish ground rules to avoid this.

I hope this email is sufficient for approval from the East Kent GP Training Programme. If not please let me know ASAP.

Best wishes

Andy

Dr Andy Charley
Northgate Medical Practice
1 Northgate
Canterbury
Kent
CT1 1WL

Tel: 01227 208556
Fax: 08708 902435

APPENDIX G

DATA ANALYSIS FOCUS GROUP

THEME 1: PERCEPTION OF SELF REFLECTION

OVERARCHING THEMES FOR WHAT PROMPTS SELF REFLECTION?

1. TYPE OF CASES-
    a. *Weird and Interesting (R1)*
    b. *Challenging (complex) and/or causing a negative impact (R1, R3)*
    c. *Successful (R5)*
    d. *Emotion evoking and certain life events (R6)*
2. UNCERTAINTY
    a. *In making decisions (R1, R4, R6)*
    b. *Checking validity of decisions (R6)*
3. KNOWLEDGE GAPS *(R1, R5)*
4. NATURAL PROCESS
    a. *Can be influenced by religion or personality (R2, R6)*
5. FEEDBACK *(R1)*

A) What is the significance of self-reflection?

OVERARCHING THEMES FOR SIGNIFICANCE OF SELF-REFLECTION

1. Learning Opportunity
    a. *Learning from Consultation (R3,R5)*
    b. *Learning from own mistakes (R4)*
    c. *Learning from others (R3)*
2. *Identification of areas for improvement (R2)*

3. *Identification of knowledge base (R2)*
4. *Increase in self-awareness (Of oneself and one's emotions) R2*
5. *Can be therapeutic (R1)*

C. How do you like to reflect?

R5: 'reflection is such a broad term and we all do it in our own way'

R1: 'Basically, all of our interactions, every single day has a degree of self-reflection in it'

R2: 'And I am sure if someone forced a Balint group, we won't like it as we will be feeling like we have been constrained. So, It is difficult'

R4: 'It just tells you how much it is easy to reflect if you relax. And not worrying about who is listening'

RESPONSES	INITIAL CODES
R5: -On a daily basis but not necessarily writing it down - It is about having conversation with someone+	On a daily basis By having conversations
R4: -Reflection on the e-portfolio not helpful - I prefer to talk to people about it; you get other people's ideas back. -	Reflection on e-portfolio not helpful By having conversations You get feedback from others
R2: Writing down my reflections, reflections about my day; It formed part of who I was. It improved my typing It forms part of my religion	By writing down flexibly It is part of my religion
R6: Mine has evolved. I used to reflect internally but now , I prefer to talk to people about my thoughts to get different	By having conversations Getting feedback from others

feedback from people; You learn from these too	
R3: It is a daily event	On a daily basis

METHODS	NEGATIVES	
Daily basis (R3, R5) By having conversations (R4, R5, R6) Getting feedback from others (R4, R6) By writing down flexibly (R2) Religion has an impact	Reflection on e-portfolio not helpful (R4)	

THEMES FOR METHODS EMPLOYED FOR REFLECTION

1. *Through Conversations (R4, R5, R6)*
2. *Written down reflections (R2)*
    a. *E-portfolio (R4)*
    b. *Private journal (R2)*
3. *Obtaining feedback (R4, R6)*

D. **What is your opinion of reflections as a General Practice Registrar?**

R1: 'They want you to have specific learning outcomes….And sometimes, it is not as easy and it is not quite clear what you have learnt or experienced'

THE EPORTFOLIO

ADVANTAGES	DISADVANTAGES
Trigger to reflect (R6) It is needed for training needs (R6) It is a way of standardising (R5)	Too structured; Not flexible (R4, R1, R2, R5, R3) Feels fake (R4, R6, R2) Not realistic (R4, R1)

	Feels forced (R4, R1, R6, R3) Concerned about who is reading (R4)

THEME 2: PERCEPTION OF VIDEO CONSULTATIONS

A. What are your views about video consultations?

R6: 'It shows your perception can be very different from how you see it in real life playing out in front of you'

RESPONSES	INITIAL CODES
R4: I hate it	Hate it
R1: I hate it too. It is so unpleasant. I don't like watching myself	It is unpleasant I don't like watching myself
R6: It is the best teacher Although I did not like watching myself too.	It is the best teacher I don't like watching myself

Q: The advantage of video

R2: 'It was one of the turning points that helped me change my practice'

R5: 'I have to re-watch my vidoes now with another trainer…. It is amazing the difference and how I have changed now'

'I think video is the best part of your learning from what you already have'

R6: 'I had certain mannerisms and I just could not understand it'

RESPONSES	INITIAL CODES
R5: You can do it down the line at some point because obviously you have the material there. It is a really powerful learning tool You can re-watch it down the line	Material is there You can re-watch later Powerful learning tool
R6: It picks up certain mannerisms, or certain ways you say things. Whether you are aware the video is there or not, you can't change that You get to see how patients react to you too For the purpose of training, it is a good tool and a learning tool on how to progress and become a better GP.	Picks up certain mannerism (Observation of attributes) Observation of patients reaction Observation of progression
R1: You can hear your voice and see your mannerisms. These are really useful Useful for improving your consultation Skills Also good for getting feedback Your supervisor can monitor your progress with it	Observation of tone and mannerisms Useful for improving consultation skills Good for getting feedback Monitoring of progress
R2: Some of ground-breaking changes to pass the exam was done through videos Someone watching with you and giving feedback is very helpful He picks up on things that I have missed	Helps to pass the College Exams Aid for feedback Someone can watch with you Someone else can also give feedback
R3: When I watch myself, I see that it is true that my voice is too low. It does help me to reflect well on myself	Personal feedback Aids reflection

The limitations of video

R3: 'It is often difficult to act naturally when you are in front of a camera'

R5: 'I guess that option could be terrifying…' – Watching with patients to get feedback

R1: ' I don't do videos regularly to self-reflect as I can't watch them back myself…. I can't bring myself to watch it'

'So again, my gaps in knowledge, complexities and uncertainties and consultation skills is what I found videos best for'

'Any time I say I need to do videos, the other doctors say…'thank God I don't need to do those anymore. So definitely, it is something they have thought about'

OVERARCHING THEMES FOR PERCEPTION OF VIDEO CONSULTATIONS

1. *OBJECTIVITY (R5)* 2. *AID FOR REFLECTION (R3)* 3. *FACTUAL OBSERVATION* a. *of personal attributes (R6, R1)* b. *of patients reaction (R6)* 4. *PROGRESS MONITORING (R6, R1)* 5. *IMPROVED PERFORMANCE* a. *In passing exams (R2)* b. *Improved Consultation skills (R1)* c. *Improved Learning (R5)* 6. *OPPORTUNITY FOR FEEDBACK (R1, R2, R3)* 7. *REFERENCING (R5)*	1. *UNNATURAL* a. *Feels fake (R4,R5)* b. *Uncomfortable (R1, R6)* 2. *ATTITUDINAL CHANGE (R5)* 3. *CHALLENGING SET UP (R3)* 4. *CHALLENGES OF CONSENT (R1, R3, R6)* 5. *PERFORMANCE ANXIETY (R1)* 6. *SUSCEPTIBILITY FOR MISTAKES (R1)* 7. *SENSITIVE* a. *For sensitive patients/ Mental health problems (R1, R6)*

THEME 3: The impact of video on self-reflection

R1: 'When we reflect without videos, we are less objective than we are when we are doing videos.'

R6: 'With the video consultations, we have almost got that photographic evidence……When you don't have a video as a mental reference, you just have your own perspective'

R5: ' Reflection without video is a more subjective and emotive experience. Whereas, with video, it is more structured, so you can make a useful reflection'

RESPONSES	**INITIAL CODES**
R5: I think it is best to self-reflect after you've seen a consultation because you will remember it.	It aids recollection of an event
R6: You see yourself how other people see you, to me that is quite powerful I think getting the other person's feedback helps your reflection too	An observation of how you are perceived Aids feedback process
R1: It is like an objective evidence and when you have not videoed, it probably has a biased view of how the consultation went.	An objective evidence Not biased (In comparison) An observation of how you are perceived
R4: It is quite good in realising how we are compared to when we reflect ourselves	

OVERARCHING THEMES FOR INTERACTION BETWEEN SELF-REFLECTION AND VIDEO CONSULTATIONS

POSITIVE VIEWS	NEGATIVE VIEWS
It aids recollection of events (R5) *Objective evidence (R1)* *Devoid of bias in reflection (R1)* *Observation of other people's perception (R6, R4)*	Non mentioned

Other comments

R1: 'I am torn between really appreciating the beneficial effects…….I just have the hate for doing it that I cant get past. When I do it, I feel stressed'

DATA ANALYSIS: OVERARCHING THEMES FOR THE INTERVIEWS

THEME 1 SELF REFLECTION

Self-reflections are important for:

Self-development (INT1, INT2, INT4)

Identifying knowledge base (INT1, INT4)

Identifying areas for improvement (INT1, INT4)

Ongoing learning (INT3)

Developing coping strategies (INT1)

Prompts for Self-reflection

It is natural (INT1)

Types of cases:

1. *Challenging (INT1, INT2, INT3, INT4*
2. *Emotion-provoking cases (INT1, INT4*
3. *Things I have done well (successful cases) (INT1)*
4. *Significant events (INT4)*
5. *Things I have not done so well; Negative impact (INT4)*

Watching others (INT2)

Knowledge Gaps (INT3, INT4)

How do you reflect?

Writing down: for e-portfolio (INT4, INT1)

Minimal distraction (INT4)

Having conversations (INT4, INT2, INT3)

Daily (INT4, INT1)

What makes a good self-reflection?

Honesty (INT1

Learning achieved (INT1)

Identified areas for improvement (INT1)

Developing new ways (INT4)

What is the advantage of self-reflection for you?

Improved communication with patients (INT4, INT2, INT1)

Developing new ways (INT4, INT1)

Improved clinical skills (INT2, INT1)

Increased confidence (INT1)

Better patient outcome (INT1)

What are the limitations?

Over analysis (INT1, INT4)

Fault finding (INT 1, INT2, INT4)

Reduction in confidence level (INT 4)

THEME 2: VIDEO CONSULTATIONS

POSITIVE VIEWS

Monitors progress (INT1)

Observation of personal attributes

a) *Mannerisms and attitudes (INT1, INT4)*
b) *Behaviour with time constraints (INT1)*

c) *Gives insight into consultation (INT4)*

Improves non-verbal communication skills (INT1, INT2, INT3, INT4)

Important for training of non-verbal communication skills (INT1)

Helpful for exam preparation (INT2)

Useful for observing others (INT2)

Objective (INT20

Useful to re-watch (INT3)

NEGATIVE VIEWS

Unnatural (INT1, INT4)

Potential to torture (INT1)

Not useful in intimate examinations (INT1)

Not useful for sensitive/anxious patients (INT1)

Causes performance anxiety (INT1, INT2, INT3, INT4)

a. *Alters decision-making (INT2, INT3)*

Difficulty in recording (INT2, INT3, INT4)

a. *In watching oneself*
b. *Needs the right attitude*
c. *Requires allocated time*
d. *Challenging to get consent*

Can be watched by others (INT3)

THEME 3: Is there any difference between quality of self-reflection or learning with or without videos?

- INT1: *'No difference for me; If you know yourself, you probably don't need to have video consultations all the time.'*
- INT2: '*Yes. Definitely……. the video serves as a reminder of the event and helps you reflect better……. You can relieve the consultation again and then reflect on something else at another time'*
- INT3: '*Yes, when it is done properly… Communications skills reflections are better…. and you can re-watch at another time. It is better than trying to*

reflect from memory…. It is more factual and more realistic for reflective purposes

- INT4*: It depends… Yes… when considering communication styles. No…as there is nothing you can't get from other methods that aid reflection as well; for example, feedback from trainer. …. gives a slightly different angle to your reflection but for me it does not change the quality or the learning I get from it.*

THEME 4: Learning style and impact on reflection

INT1: *'The learning style of an individual can be used to help a person to develop reflective skills that they are naturally inclined to'*

INT3: *'I like to write things down and I remember which helps to reflect….It aids my recall afterwards….My learning style probably impacts on why I don't find videos personally helpful as I prefer to hear and write things down for my reflection that watch'*

INT4*: 'I am very visual and that is why reflections stay with me. It is very painful and generates anxiety. When I reflect with videos, it makes the experience more painful especially when things have not gone well'*

THEME 5 Do you think video consultations aid self-reflection?

INT2*: 'I think definitely in checking non-verbal communication styles…it offers a place for good self-reflection. ……It offers a great learning opportunity*

INT3: *'It will not be my first point of call to aid self-reflection'*

MERGED THEMES

OVERARCHING THEMES FOR WHAT PROMPTS SELF REFLECTION?

TYPE OF CASES-

- *Weird and Interesting (R1)*
- *Challenging (complex) and/or causing a negative impact (R1, R3, INT4)*
- *Successful (R5, INT1)*
- *Emotion evoking and certain life events (R6, INT1, INT4)*
- *Significant events (INT4)*

UNCERTAINTY

- *In making decisions (R1, R4, R6)*
- *Checking validity of decisions (R6)*

KNOWLEDGE GAPS *(R1, R5, INT3, INT4)*

NATURAL PROCESS

- *Can be influenced by religion or personality (R2, R6, INT1)*

FEEDBACK *(R1)*

- *Watching others (INT2)*

OVERARCHING THEMES FOR SIGNIFICANCE OF SELF-REFLECTION

6. Learning Opportunity
    a. *Learning from Consultation (R3,R5)*
    b. *Learning from own mistakes (R4)*
    c. *Learning from others (R3)*
    d. *Ongoing learning (INT3)*
7. *Identification of areas for improvement (R2, INT1, INT4)*
8. *Identification of knowledge base (R2, INT2, INT4)*
9. *Increase in self-awareness (Of oneself and one's emotions) R2*
    a. *Self-development (INT1, INT2, INT4)*

10. *Can be therapeutic (R1)*

11. *Developing coping strategies (INT1)*

How do you like to reflect?

R5: 'reflection is such a broad term and we all do it in our own way'

R1: 'Basically, all of our interactions, every single day has a degree of self-reflection in it'

R2: 'And I am sure if someone forced a Balint group, we won't like it as we will be feeling like we have been constrained. So, It is difficult'

R4: 'It just tells you how much it is easy to reflect if you relax. And not worrying about who is listening'

THEMES FOR METHODS EMPLOYED FOR REFLECTION

4. *Through Conversations (R4, R5, R6, INT2, INT3, INT4)*
5. *Written down reflections (R2)*
    a. *E-portfolio (R4, INT4, INT1)*
    b. *Private journal (R2)*
6. *Obtaining feedback (R4, R6)*
7. *Minimal distraction (INT4)*
8. *Daily (INT4, INT1)*

What makes a good self-reflection?

Honesty (INT1

Learning achieved (INT1)

Identified areas for improvement (INT1)

Developing new ways (INT4)

What is the advantage of self-reflection for you?

Improved communication with patients (INT4, INT2, INT1)

Developing new ways (INT4, INT1)

Improved clinical skills (INT2, INT1)

Increased confidence (INT1)

Better patient outcome (INT1)

What are the limitations?

Over analysis (INT1, INT4)

Fault finding (INT 1, INT2, INT4)

Reduction in confidence level (INT 4)

OVERARCHING THEMES FOR PERCEPTION OF VIDEO CONSULTATIONS

OBJECTIVITY (R5, INT2) *AID FOR REFLECTION (R3)* *FACTUAL OBSERVATION* a. *of personal attributes (R6, R1, INT1, INT4)* b. *of patient's reaction (R6)* c. *Behaviour with time constraints (INT1)* d. *Gives insight into consultation (INT4)* e. *Of others to learn from them (INT2)* *PROGRESS MONITORING (R6, R1, INT1)*	*UNNATURAL* c. *Feels fake (R4,R5)* d. *Uncomfortable (R1, R6, INT1, INT4)* *ATTITUDINAL CHANGE (R5)* *CHALLENGING SET UP AND RECORD (R3, INT2, INT3, INT4):* a. *In watching oneself* b. *Needs the right attitude* c. *Requires allocated time* d. *Challenging to get*

IMPROVED PERFORMANCE *d. In passing exams (R2, INT2)* *e. Improved Consultation skills (R1)* *f. Improved Learning (R5)* *g. Improved non-verbal communication skills (INT1, INT2, INT3, INT4)* *OPPORTUNITY FOR FEEDBACK (R1, R2, R3)* *REFERENCING (R5, INT3)* *ESSENTIAL FOR TRAINING: non-verbal communication skills. (INT1)*	*consent* *CHALLENGES OF CONSENT (R1, R3, R6)* *PERFORMANCE ANXIETY (R1, INT1, INT2, INT3, INT4)* *SUSCEPTIBILITY FOR MISTAKES (R1)* *SENSITIVE:* *b. For sensitive patients/ Mental health problems (R1, R6, INT1)* *c. Intimate examinations (INT1)* *COUNTER-PRODUCTIVE (INT1); Potential to torture.* *ALTERS DECISION MAKING (INT2, INT3)* *WATCHED BY OTHERS (INT3)*

RECODED THEMES FOR THE PERCEPTION OF VIDEO IN GP SETTING

Overall Themes to be used to discuss results

1. **Challenge of perception**
2. **Feasibility of video use in GP setting**
3. **Acceptability of video use in GP setting**
4. **Validity of video use in GP setting**

OVERARCHING THEMES FOR INTERACTION BETWEEN SELF-REFLECTION AND VIDEO CONSULTATIONS

POSITIVE VIEWS	NEGATIVE VIEWS
It aids recollection of events (R5) *Objective evidence (R1)* *Devoid of bias in reflection (R1)* *Observation of other people's perception (R6, R4)*	Non mentioned

THEME 3: Is there any difference between quality of self-reflection or learning with or without videos?

- INT1: *'No difference for me; If you know yourself, you probably don't need to have video consultations all the time.'*

- INT2: '*Yes. Definitely……. the video serves as a reminder of the event and helps you reflect better……. You can relieve the consultation again and then reflect on something else at another time'*
- INT3: '*Yes, when it is done properly… Communications skills reflections are better…. and you can re-watch at another time. It is better than trying to reflect from memory…. It is more factual and more realistic for reflective purposes*
- INT4*: It depends… Yes… when considering communication styles. No…as there is nothing you can't get from other methods that aid reflection as well; for example, feedback from trainer. …. gives a slightly different angle to your reflection but for me it does not change the quality or the learning I get from it.*
- 8 out of 10 = Yes. Why? For mostly non-verbal cues in communication
- 1 out of 10= Yes and No- It does not but can offer a different angle for reflection when re-watched later
- 1 out of 10 = No. If you are naturally reflective, it does not change quality
- It is also dependent on your level of experience or how long you have been in practice for.

THEME 5 Do you think video consultations aid self-reflection?

- INT2*: 'I think definitely in checking non-verbal communication styles…it offers a place for good self-reflection. ……It offers a great learning opportunity*
- INT3: *'It will not be my first point of call to aid self-reflection'*

How video-recorded consultations aid reflection:

1. It aids memory or recollection of events
2. It serves as a trigger for reflection
3. It provides objectivity
4. Identifies what to reflect on

5. Offers structure for reflection
6. Consolidates feedback for reflection
7. Can be referenced now and again.

THEME 4: Learning style and impact on reflection

INT1: *'The learning style of an individual can be used to help a person to develop reflective skills that they are naturally inclined to'*

INT3: *'I like to write things down and I remember which helps to reflect….It aids my recall afterwards….My learning style probably impacts on why I don't find videos personally helpful to improve the quality of my reflection as I prefer to hear and write things down for my reflection than watch'*

INT4*: 'I am very visual and that is why reflections stay with me. It is very painful and generates anxiety. When I reflect with videos, it makes the experience more painful especially when things have not gone well'*